STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
2829 Watt Avenue
P.O. Box 214405
Sacramento, California 95821-0405

CAL ARNG Pamphlet
No. 40-2

9 July 1990

Medical Services
INJURY AND DISEASE - LINE OF DUTY REPORTS

This pamphlet establishes policy and provides guidance for implementation and processing administrative requirements related to injuries, diseases and death for soldiers of the California Army National Guard.

The proponent of this pamphlet is the Director, Military Personnel (CAMP). Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes of Publications and Blank Forms) directly to the Adjutant General, State of California, ATTN: CAMP-SB, 2829 Watt Avenue, P.O. Box 214405, Sacramento, California 95821-0405.

*This Pamphlet supersede CAL ARNG Pam 40-2, 1 October 1980.

CHAPTER 4 - LINE OF DUTY

CHAPTER 5 - INCAPACITATION (INCAP) PAYROLL

CHAPTER 6 - STATE COMPENSATION INSURANCE FUND

CHAPTER 7 - MEDICAL EVALUATIONS

CHAPTER 1
GENERAL

1-1. **PURPOSE.** This pamphlet is designed to provide guidelines for the administrative procedures, required documentation, and information for soldiers who incur duty related injury, diseases or death.

1-2. **RELATED PUBLICATIONS.** The procedures outlined in this pamphlet are current as of the date above. Policies, requirements, and procedures reflect those listed in the beginning of each chapter. Refer to Appendix G for listed references.

1-3. **APPLICABILITY.** This pamphlet applies to each member of the California Army National Guard (CA ARNG) on Federal Active Duty or Inactive Duty status except those soldiers on Active Guard and Reserve (AGR); Federal Technician employment status; and State Civil Service. This pamphlet also applies to members of the State Military Reserve on State Active Duty Status only.

a. Active Guard and Reserve (AGR) refer to the AGR Standard Operating Procedures (SOP).

b. Federal Technicians refer to the Federal Personnel Manual 810.

c. State Civil Service members refer to CAL ARNGR 690-3, dated 11 Feb 87.

1-4. **RESPONSIBILITY.** The Office of the Adjutant General, Directorate of Military Personnel, Support Branch (CAMP-SB) has primary responsibility for administrative processing of all actions related to injury, diseases or death incurred by California National Guard members, except as listed in para 1-3 (A-C).

a. Unit commanders are responsible for reporting all incidents of injury, disease or death which occur during periods of training and related duty to the OTAG Emergency Operations Center as required in CAL ARNG 190-40.

b. Service members are responsible for meeting all requirements to include reporting to appropriate military medical facilities as directed. Failure to comply with the provisions of this and related regulations could result in the loss of benefits.

CHAPTER 2
REPORTING REQUIREMENTS

2-1. **GENERAL.** This chapter prescribes reporting requirements incident to the disease, injury, disability or death of a California Army National Guard soldier. Reference CAL ARNGR 190-40.

2-2. **REPORTING RESPONSIBILITY.** The unit commander or officer having administrative responsibility for soldiers who become ill, injured, disabled, or die will report by telephone through operational channels, to the Staff Duty Officer (SDO) or Emergency Operations Center (EOC), Office of the Adjutant General. The EOC 24 hour phone number is (916) 973-3441. This telephonic notification is referred to as a serious incident report (SIR).

2-3. **TYPES OF REPORTABLE INJURIES/DISEASE/DEATH.**

a. Injury as a result of negligence or willful misconduct, including drugs and alcohol.

b. Treatment by a civilian medical facility and/or active duty military medical facility.

c. Treatment requiring follow-up care at a civilian or military facility.

d. A medical condition diagnosed by a physician as causing disability or impairment.

e. Medical condition that require confinement to the Troop Medical Facility (TMC) 12 hours or more while on federal or state status.

f. Incidents requiring a line of duty investigation.

g. Incidents while on State Active Duty (SAD) status for an emergency SAD mission.

CHAPTER 3
BENEFITS

3-1. **PURPOSE.** This chapter outlines the benefits authorized, source of entitlement and/or care and the reference for injured or ill soldiers of the California National Guard.

3-2. **BENEFITS**

BENEFIT	SOURCE OF ENTITLEMENT AND/OR CARE	REFERENCE
1. Treatment of injury/ disease incurred while under any Federal status	Federal incapacitation compensation and/or State Compensation Insurance.	NGR Pam 37-5, Sec 340 & Mil & Vet Code
	Army expense, Army or Federal Facility, Civilian Facility in emergency.	Para 4-2, AR 40-3, Para 6 NGR 40-3
2. Glasses, dental or artificial limbs or devices	Army Expense, Federal Facility in course of treatment of injuries, or when lost, damaged or destroyed. Not the result of negligence or misconduct. May go to Civilian Facility with prior approval of NGB and statement of urgency from unit commander.	Para 5e, NGR 40-3
3. Transporation to and from treatment	Unit vehicles or TR, Army Expense (CAL FORM 40-6-1)	JTR Para M6005, Para 5-6, NGR 37-104-2
4. Pay and allowances during hospitalization or disability.	Federal incapacitation compensation. 1. Old Law-Injury incurred before 16 Nov 86.	DOD Pam, Tbl 8-2-4 Para 4-2, AR 40-3, Chap 5, NGR 37-104-2, NGB Pam 37-5
	2. Public Law-99-661 injury/disease incurred between 16 Nov 86-29 Sep 88.	NGR Pam 37-5, CAL Pam 40-2
	3. Public Law-100-456 injury/disease incurred on or after 30 Sep 88.	CAL Pam 40-2, Chap 5
	State Compensation Insurance (Not pay & allowances).	See 340 & 341

BENEFIT	SOURCE OF ENTITLEMENT AND/OR CARE	REFERENCE
5. Reemployment rights after disability.	State and Federal Labor Codes.	Sec 394, CAL MIL & Vet Code
6. Disability Retirement	Federal Government and/or State.	AR 635-40, Para 10, NGR 40-3, Sec 340 & 341, Mil & Vet Code, Chap 8 AR 635-40
7. Death Benefits	Federal Government and/or State	See CAL ARNGR 600-10

CHAPTER 4
LINE OF DUTY (LOD)

4-1. **PURPOSE.** This chapter prescribes procedures for investigating the circumstances under which the injury, disease or death of a member was incurred. It also provides considerations in determining line of duty (LOD) status. Further, this chapter establishes required documents and administrative procedures for processing line of duty investigation.

4-2. **APPLICABILITY.** This pamphlet applies to each member of the Army National Guard (ARNG) who incurs an injury or disease in LOD while performing authorized training. An LOD investigation is also required in deaths that occurred while in a training status, or traveling to or from duty.

4-3. **IMPORTANCE OF LINE OF DUTY ACTIONS.** LOD determinations are used to decide entitlement to a member for benefits administered by the Department of the Army. The facts determined in the investigation may also assist the Veterans Administration and state and local agencies in deciding the individual's entitlement to benefits under the programs which they administer.

4-4. **AUTHORITIES, DUTIES AND RESPONSIBILITIES.**

a. Chief, National Guard Bureau is the final approving authority for all formal LOD's.

b. The California State Adjutant General is the reviewing authority for all cases. The Adjutant General (TAG) may also act as the final approving authority for informal determinations.

c. The Unit Commander or officer having administrative responsibility for the member concerned will:

(1) Insure that each soldier understands the requirement to report injuries and diseases incurred with incident to training and understands the benefits which may be authorized.

(2) Take prompt action to investigate the LOD status of each member incurring a injury or disease incident to training.

(3) Insure that a determination is obtained from the treating physician on the DD Form 2173, Section I (to include signature).

(4) Submit all documents required to assist in a final determination as listed in this pamphlet. (Refer to para 4-7 thru 4-11).

(5) Ensure that all documents submitted are factual and administratively correct; that the period of injury is consistent with those periods of duty actually performed by the injured or diseased soldier.

(6) In the case of a formal investigation, assist the investigating officer in obtaining information.

d. Soldiers who incur injuries or diseases incident to training will promptly notify their unit commander or the officer having administrative responsibility.

e. Administrative personnel and other unit personnel involved in the preparation of a line of duty report are responsible for the prompt and accurate accomplishment of required actions. CAL ARNG Form 40-2 will be completed and utilized to forward all required documents.

4-5. TYPES OF LINE OF DUTY INVESTIGATIONS.

a. Administrative LODs are only required to be forwarded to the office of the Adjutant General (OTAG) if there is a civilian medical bill. If there is no civilian medical treatment, administrative LOD reports should be filed in the official Military Personal Records Jacket (MPRJ).

(1) Administrative LODs must not contain evidence of misconduct, neglect, AWOL or prior injury. (Refer to Formal Line of Duty, para 4-10).

(2) An administrative LOD covers treatment which is completed during the duty period only. Treatment or disability after the training period must be considered in an Informal Line of Duty. (Refer to Informal LOD, para 4-9).

b. Informal Line of Duties are required if there is treatment or disability following the training period and there is no evidence of misconduct, neglect, AWOL or death.

c. Formal Line of Duties are required for the following reasons:

(1) Injury or disease incurred not in line of duty (or not in a duty status).

(2) Injury as result of misconduct or gross negligence.

(3) Injury or disease which occurred during unauthorized absence.

(4) Suicide attempt or other mental, psycho-neurotic or personality disorder.

(5) Injury or disease that existed prior to service, aggravated by service.

(6) Medical condition that may result in permanent disability.

(7) Any condition that resulted in death.

(8) Disease condition.

(9) While traveling to or from training to home stations.

(10) As directed by OTAG.

4-6. ADMINISTRATIVE LINE OF DUTIES REQUIREMENTS.

a. Administrative LOD is only required to be forwarded to the Office of The Adjutant General (OTAG) if there is a civilian medical bill. If there is no civilian medical treatment, LOD should be filed in official MPRJ. Administrative LOD is appropriate when treatment is completed during the duty period with no additional treatment required following the duty period.

b. Refer to paragraph 4-10, Formal Line of Duty if evidence of misconduct, neglect, AWOL or prior injury is present.

c. Refer to paragraph 4-9, Informal Line of Duty if treatment or disability continues beyond the training period.

4-7. **REQUIRED FORMS TO COMPLETE AN ADMINISTRATIVE LINE OF DUTY.** CAL ARNG Form 2173 Statement of Medical Examination and Duty Status. (Reference Appendix A).

a. Section 1 - Completed and signed by the treating physician or hospital administrator.

b. Section 2 - Completed and signed by the unit commander or administrative officer.

c. Medical treatment records.

d. Training schedule/orders.

e. DA Form 2823 for member/witness(es)

4-8. **INFORMAL LINE OF DUTY REQUIREMENTS.** Informal LODS are only required if there is treatment or disability following the training period. An informal LOD is not appropriate if there is evidence of misconduct, neglect or AWOL. Incapacitation payroll is forwarded with the Informal and Formal Line of Duty when soldier is incapacitated beyond the training period.

4-9. **REQUIRED FORMS TO COMPLETE AN INFORMAL LINE OF DUTY.** (Reference Appendix B).

a. CAL ARNG Form 2173, Statement of Medical Examination and Duty Status.

b. DD Form 2823, Sworn Statement. Use for <u>both</u> injured soldier and witness statements. Statements do not require soldiers to be sworn or advised of their rights. (Refer AR 600-8-1 para 400-3c 1-2).

c. Medical treatment records from both civilian and military medical facilities as appropriate.

d. Documentation that reflects the duty period and status at the time of the injury or disease. (i.e. Annual Training orders or IDT Training Schedules).

e. Other documents as required which assist in the determination of eligibility for benefits. Example: accident reports, physicals, etc.

4-10. **FORMAL LINE OF DUTY INVESTIGATION.**

a. A Formal Line of Duty investigation is required when there is evidence that the injury or disease is:

(1) Incurred not in the line of duty or not in a duty status.

(2) A result of misconduct or gross negligence.

(3) Incurred during unauthorized absence.

(4) A suicide attempt or related to mental, psycho-neurotic or personality disorder.

(5) An injury or disease that existed prior to service, and aggravated by service.

(6) A medical condition that may result in permanent disability.

(7) A condition that resulted in death.

(8) Caused by a disease condition.

(9) Incurred traveling to or from training to home station.

(10) As directed by OTAG.

b. The senior command will appoint an investigating officer on orders.

4-11. **REQUIRED FORMS TO COMPLETE A FORMAL LINE OF DUTY INVESTIGATION.** (Reference Appendix C).

a. Order appointing investigating officer.

b. DD Form 261, Report of Investigation.

c. CAL ARNG Form 2173, Statement of Medical Examination and Duty Status.

d. DD Form 2823, Sworn Statement. Use for both injured soldiers and witness statements. (Refer AR 600-8-1 Para 40-3c 1-2).

e. Medical reports (Military/Civilian medical facilities as appropriate).

f. Rights warning procedures/waiver certificate DA Form 3881. (Only if member is suspected of any offenses, misconduct or drug and alcohol use).

g. Accident/Police Report (if applicable).

h. Documentation that reflects the duty period and status at the time of injury or disease. (i.e. Annual Training Orders or IDT Training Schedules).

i. Adverse letter if found not in line of duty (refer AR 600-8-1 figure 40-5 exhibit K)

4-12. **JAG REVIEW.** All completed formal investigations must have a Judge Advocate General (JAG) review. JAG reviews will be coordinated by the Support Branch, OTAG, for the purpose of:

a. Determination of whether legal requirements have been complied with.

b. Ascertain if any errors exists and if so, whether such error has a material or adverse effect on any individuals rights.

c. Determine whether the findings of the investigation are supported by substantial evidence or lack of it.

d. Examine the investigation to see if potential claims may be involved. This is of special concern where medical care has been furnished and the Government may be entitled to recover third party medical claims.

4-13. **APPROVAL.** All LOD investigations must be routed through the next higher command. The Battalion Administrative Officer or senior full-time supervisor will certify for accuracy and completeness using transmittal form CAL ARNG 40-2.

CHAPTER 5
INCAPACITATION (INCAP) PAYROLL

5-1. **PURPOSE.** This chapter prescribes the procedure for initiating an incapacitation payroll. In addition, it explains the public laws that govern the granting of incapacitation pay and describes the criteria and forms needed to submit a complete incapacitation payroll.

5-2. **APPLICABILITY.** This chapter applies to Army National Guard M-Day soldiers who are incapacitated beyond the training period. The injury or disease must have been found to be in the line of duty.

5-3. **PUBLIC LAWS.** There are three Public Laws that have been enacted by Congress that govern the awarding of incapacitation pay depending on the date of injury.

a. The "Old Law" - Pertains to injuries received on/or before 16 November 1986. The soldier is paid full military pay and allowances, regardless of civilian job status.

b. Public Law 99-661 - Includes injuries incurred between 17 November 1986 - 29 September 1988.

(1) Soldier must have incurred a loss of income. The burden of proof is with the soldier. Soldier can receive compensation for loss of non-military income up to full military pay and allowances.

(2) Unemployed soldiers receive Drill pay only.

c. Public Law 100-456 - Pertains to injuries from 30 September 1988 to present, as follows:

(1) If an unemployed soldier found unfit for military duty by a doctor is eligible for full military pay and allowances per rank and PEBD.

(2) If a soldier is found unfit for military duty by a doctor but is able to work at his/her civilian job, he/she receives full military pay and allowances per rank and PEBD minus any earned income from his/her civilian job (Drill pay is not authorized if civilian income exceeds full military pay and allowances). Earned income is defined as "income from salaries, wages, business profits, commissions, tips and unemployment compensation."

(3) If a soldier is found fit for military duty by a doctor but is unable to work at his civilian job, he/she receives incap pay for his loss of civilian income up to full military pay and allowances per his rank and PEBD.

(4) An unemployed soldier who is determined fit for military duty by a doctor in his MOS duties and requirements but is still not medically cured 100% does not receive incapacitation pay.

5-4. **INCAPACITATION PAYROLL FORMS REQUIRED.** Initial request for incapacitation pay should accompany the LOD. Subsequent request for incapacitation pay should be made every 30 days. (Reference Appendix D).

a. CAL NG Form 37-2C: Request for Approval for Incapacitation Pay.

b. CAL ARNG Form 37-9: ADAPS Payroll Certificate. (each payroll).

c. CAL NG Form 40-6-2: Disability Statement. A new CAL ARNG Form 40-6-2 must be included in every payroll. The soldier must continue to go to the military physician every month.

d. CAL NG Form 37-D: Disability Counseling Statement. This statement outlines the responsibilities and requirements of the soldier who receives incapacitation pay. After the soldier has read and signed the disability counseling statement, he should be provided with a copy for his records. (Required with the initial payroll only).

e. CAL NG Form 37-2E: Employer Statement. A new employers statement must accompany each new payroll submitted to OTAG. It must be signed and dated by the employer. If employee has received any sick leave or annual leave, the dates received will be included on the form. (If the soldier is self-employed CAL NG Form 37-2F Self-Employed Statement will be substituted).

f. Check Stubs: Include a copy of the last two check stubs from the soldier. (Required with the initial payroll only).

g. CAL NG Form 37-2H: Soldier Claim Form. Must be completed and signed each month.

h. CAL ARNG Form 40-2 (Appendix) will be utilized to transmit all incapacitation payrolls to Support Branch, OTAG for necessary action.

5-5. **OTHER DOCUMENTS.** The first incapacitation payroll submitted to OTAG will include the CAL NG Form 37-D, two check stubs and a copy of the military orders or IDT Training Schedule, Certificate of Training, RMA, or SUTA.

5-6. **APPROVALS.** There are three levels of approval for incapacitation pay. The authority level depends upon the duration the soldier receives incapacitation pay.

a. The first 90 days of paid incapacitation is approved by OTAG.

b. The next 90 days of paid incapacitation is approved by National Guard Bureau (NGB).

c. For all cases beyond 180 days, HQ, Department of the Army approval is required.

5-7. **Payroll Processing.** A completed incapicitation payroll will be reviewed and authorized by Support Branch, OTAG and forwarded to the United States Property and Fiscal Office (USPFO) for processing. USPFO forwards the payroll to the U.S. Army Finance and Accounting Office for payment. The actual check is issued from the Presidio of San Francisco and sent directly to the individual.

CHAPTER 6
STATE COMPENSATION INSURANCE FUND (SCIF)

6-1. **GENERAL.** The Office of The Adjutant General insures State employees for illness or injury received in the performance of their duties. The program provides benefits in the form of temporary disability pay (TD), rehabilitation, vocational training, placement and other services as required. Payment of medical bills and benefits is administered through SCIF offices statewide. Benefits are assigned upon request from the employing state agency (i.e. California National Guard) and continue until an employee is returned to duty or a permanent disability settlement is awarded. No state benefits may be awarded that duplicate any federal benefits received by the individual.

6-2. **ELIGIBILITY.** Personnel in the California National Guard who are not permanent employees in the Office of The Adjutant General are considered State employees under the provisions of Section 340 California Military and Veterans Code. This status is applicable during drills, annual training, state emergencies and other duties as directed by the commander in an official status.

6-3. **APPLICATION PROCEDURES.** Application for benefits must be submitted to the Office of The Adjutant General, Support Branch, 2829 Watt Avenue, Sacramento CA 95821-0405.

6-4. **REQUIRED FORMS.** The following documents are required. (Reference Appendix E)

a. SCIF Form 3067: Employers Report of Occupational Injury or Illness.

b. SCIF Form 3301: Employee's Claim for Workers Compensation Benefits.

c. DD Form 2823: Sworn Statements. Use for both injured soldier and witness statements. Statements do not require soldier be sworn or advised of their rights.

d. A repayment agreement form is required if applicant has requested federal benefits for the same injury/illness. State law prohibits receipt of duplicate benefits. All temporary SCIF benefits must be repaid by the applicant upon receipt of federal benefits.

6-5. **PROCESSING PROCEDURES.** The Support Branch, Office of The Adjutant General reviews applications to determine eligibility for benefits. SCIF Form 3067 is completed and authenticated for submission to the regional SCIF office proximate to the soldier's home of record. The SCIF office establishes a direct relationship with the applicant. The SCIF office generally coordinates with the Office of The Adjutant General to determine the appropriate type of compensation and/or benefits that will be provided.

6-6. **RESTRICTIONS/DENIAL/APPEALS.** The California Military and Veterans Code precludes award of duplicate benefits for personnel also receiving federal benefits. A soldier cannot receive federal incapacitation pay and state temporary disability pay for the same injury/period. It is possible that a soldier could receive state and federal benefits if it is determined that they are mutually exclusive. Benefit applications may be denied by the Office of The Adjutant General or the regional SCIF office for a variety of reasons to include: insufficient documentation, injury/illness did not occur while in a state status, misconduct, alcohol/drug involvement or duplicative federal benefits. Appeals for denied applications may be submitted to the Workers Compensation Appeals Board. In these cases a judge will hear the appeal. Individuals are responsible for securing their own representation (if they desire a lawyer) for these proceedings.

6-7. RELATED PUBLICATIONS/REFERENCES.

California Military and Veterans Code
California Labor Code
SCIF Pamphlet 13710 (Your Guide to Workers Compensation)
SCIF Pamphlet 13769 (Workers' Compensation Reform)

CHAPTER 7
MEDICAL EVALUATIONS

7-1. **GENERAL.** If a soldier cannot perform MOS duties due to mental or physical problems, a medical/psychological evaluation may be requested by the soldiers unit commander. An evaluation will be made to determine fitness for duty which may result in MOS reclassification or discharge.

a. A medical/psychological evaluation is requested by memorandum. Requests must include back-up information, medical records and statements, etc.

7-2. **SUBMISSION.** The commander's request for medical/psychological evaluation is sent to OTAG, ATTN: CAMP-SB. A two month suspense date is placed on the transmittal letter to the 175th Medical Brigade. A copy of the transmittal letter is sent to the requesting unit by CAMP-SB.

a. Once an appointment is scheduled, the applicable medical unit will notify the soldiers unit as to the time and date of the appointment. The unit is responsible for contacting the soldier and arranging transportation to the medical facility for the evaluation.

b. It is mandatory that the soldier attend the scheduled medical evaluation appointments. The Unit Commander has the discretion to discharge a soldier for failure to keep a scheduled medical appointment in accordance with NGR 600-200.

7-3. **COMPLETION.** Once the medical/psychological evaluation is completed, it will be transmitted with DA Form 3349 to CAMP-SB by the examining facility.

a. The soldier is able to return to duty if given a profile of a "1" or "2" unless otherwise restricted by his MOS as identified in AR 611-201. The unit will be notified of soldiers status.

b. A soldier with a profile of "3" or "4" may be subject to reclassification or discharge. The Unit Commander will be notified and has the responsibility to make this decision and respond to CAMP-EPMS before the suspense date.

CHAPTER 8
DEATH CASES

8-1. **DEATH NOTIFICATION.** Upon notification of death, it is the units responsibility to call the Emergency Operations Center (EOC) (916) 973-3440 to make a Serious Incident Report (SIR). Once the EOC is notified, the unit should immediately notify Support Branch (916) 973-3335 for initiation of an Advance Report, Servicemens Group Life Insurance (SGLI) paperwork, appointment of a survivor's assistance officer and notification procedures for next of kin (if necessary).

8-2. **REQUIRED INFORMATION.** Information required to initiate a Report of Death. (Refer to Appendix F).

a. Soldiers name, social security number and rank.

b. Date, place and cause of death.

c. Date and place of birth, race and religious preference.

d. Was soldier in duty status at time of death?

e. Beneficiaries (name, address, and relationship to deceased).

f. Date of record of Emergency Data Form (DD Form 93).

g. Person handling funeral arrangements.

h. Date, time and place of service.

i. Was soldier a technician?

j. Was soldier married? Any children?

8-3. **SGLI DOCUMENTATION.** The unit is to furnish to Support Branch, OTAG the following documentation for initiation of SGLI processing. (Refer to Appendix F)

a. Report of Death (see para 12-7, AR 600-8-1 for format).

b. A Certified Death Certificate (Original copy).

c. DA Form 41 or DD Form 93 and VA Form 29-8286.

d. Copy of last two leave and earning statements on which SGLI was deducted.

e. Military Personnel Records Jacket (if not at CAMP-CARE).

f. Statement of number of assemblies for which pay is due (may be included on report of death).

g. A copy of the unit training schedule (only if on duty status).

h. Police reports and coroners reports are required if death was caused by other than natural causes.

i. CAL ARNG Form 40-2 (Appendix) will be utilized to transmit all documents to Support Branch, (CAMP-SB) OTAG.

CHAPTER 9
MEDICAL BILLS

9-1. **PURPOSE.** This chapter explains the procedures for submitting medical bills related to treatment authorized in the line of duty.

9-2. **APPLICABILITY.** All itemized medical bills received by a unit or a service member related to treatment received for injury or disease will be forwarded to OTAG, ATTN: CAMP-SB for determination and processing. This section applies to all soldiers no matter their status, (AGR, AT or IDT).

9-3. **AUTHORITY FOR TREATMENT.** Treatment in a civilian medical or dental facility is not authorized without prior written or verbal authorization by the Chief, National Guard Bureau or his designee.

a. Treatment obtained without authorization or treatment not related to the injury incurred in the line of duty is the personal responsibility of the soldier.

b. Treatment obtained as a result of injury or disease found not to be in the line of duty may be the personal responsibility of the soldier.

c. Medical bills received by OTAG, CAMP-SB that are found not in the line of duty or unauthorized will be forwarded to the individual soldier for payment. The soldiers unit will be notified of the action. The unit will counsel the soldier on his/her responsibility for payment and the treatment facility/hospital will be notified by Support Branch.

9-4. **AUTHORIZED PAYMENT.**

a. Medical bills are authorized for payment upon approval of the line of duty.

b. Medical bills received by Support Branch with line of duty action still pending will be held unit line of duty determination is complete.

c. Medical bill(s) under $2,500 total are authorized for payment by the Support Branch, OTAG and processed for payment by USPFO.

d. Medical bills over $2,500 total require National Guard Bureau authorization. Processing and payment takes up to 60 days.

APPENDIX A

TRANSMITTAL FORM

The proponent of this form is CAMP-SB. See CAL PAM 40-2 for complete instructions.

☒ Line of Duty ☐ Incapacitation ☐ Death ☐ Medical Bills ☐ Other

Office of the Adjutant General State Military Forces ATTN: CAMP-SB P. O. Box 214405 Sacramento, CA 95821-0405	From: Cdr, 40th Personnel Svc Company 440 Arden Way Sacramento, CA 95828-0000

Date: 25 May 1989	POC: SFC Madison, Charles	Phone: (916)788-0098

USAGE: All source documents sent to Support Branch are logged in and out to provide control at all levels and to furnish an audit trail.

INSTRUCTIONS TO COMPLETE FORM: Check-off inventory items attached and obtain signature of BN or MACOM Administrative Officer (AO). Forward to OTAG, ATTN: CAMP—SB Box #20. Special Instructions are provided on the reverse side of this form. See CAL PAM 40-2 for complete instructions.

SOLDIER'S NAME: SSG LOVE, Larissa M. SSN: 124-00-0081 DOI: 23 Apr 89

DOCUMENT INVENTORY FOR LOD:

INFORMAL LOD

- ☐ CAL ARNG Form 40-2
- ☐ CAL ARNG Form 2173
- ☐ Injured Soldier's Statement (DD Form 2823) #1
- ☐ Witness Statement(s) (DD Form 2823) #1
- ☐ Medical Treatment Records (CAL NG Form 40-6-2) #8
- ☐ AT Orders/IDT Training Schedule #6
- ☐ Other Documents #2

FORMAL LOD

- ☐ CAL ARNG Form 40-2
- ☐ DD Form 261
- ☐ Order Appointing Investigating Officer.
- ☐ CAL ARNG Form 2173
- ☐ Letter of Adverse Personnel Action #7
- ☐ Injured Soldier's Statement (DD Form 2823) #1
- ☐ Witness Statement(s) (DD Form 2823) #1
- ☐ Medical Treatment Records (CAL NG Form 40-6-2)
- ☐ DA Form 3881 Rights Warning #3
- ☐ Accident/Police Report #4
- ☐ Map (showing direct route) (As Required)
- ☐ AT Orders/IDT Training Schedule #6

ADMINISTRATIVE LOD

- ☒ CAL ARNG Form 40-2
- ☒ CAL ARNG Form 2173

See special instructions.
(Refer to reverse side for INCAP and DEATH inventory)

Administrative Officer Certification:

I certify that I have personally reviewed the attached documents and found them to be correct and complete in accordance to CAL PAM 40-2.

25 May 1989
DATE OF CERTIFICATION

GEORGE G. SCOTT/MAJ
PRINT/TYPE NAME/RANK AND SIGNATURE

CAL ARNG Form 40-2

APPENDIX A (continued)

INCAPACITATION PAYROLL

1. Initial Payroll:

- ☐ CAL ARNG Form 40-2
- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2/Doctors Statement
- ☐ CAL NG Form 37-D
- ☐ CAL ARNG Form 2173, with approval
- ☐ DA Form 261, with approval
- ☐ AT Order/IDT Training Schedule

2. Additional Payrolls

- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2 #8

DEATH CASE

- ☐ CAL ARNG Form 40-2
- ☐ Death Report Example AR 10-7 para 10-7
- ☐ Certified Death Cert.
- ☐ DD Form 93
- ☐ VA Form 29-8286
- ☐ Last three LES
- ☐ MPRJ File #5
- ☐ Statement of pay due
- ☐ Unit Training Schedule #6
- ☐ Police Report*
- ☐ Coroner Report*

*Depending on the cause of death (gun shot wound, auto accident, etc).

SPECIAL INSTRUCTIONS

1. DD Form 2823 should be used if available.Plain bond or notebook paper can be substituted.
2. Submit other documents as required to assist in the investigation/determination. (physicals, accident reports, maps, etc).
3. Rights warning are required only if soldier is suspected or accused of any offense under the UCMJ.
4. Accident/police report are required if a vehicle accident is directly related.
5. Forward MPRJ unless stored at CAMP-CARE. (Indicate MPRJ's location in comments.)
6. AT Orders/IDT training Schedule are required when on duty status.
7. Letter of notification for not-in-line-of-duty findings and adverse personnel action pending.
8. CAL ARNG Form 40-6-2 must be submitted with each INCAP payroll request. A doctor's medical statement can be substituted in place of the CAL ARNG Form 40-6-2.

COMMENTS:

CAL ARNG Form 40-2 (26 Mar 90) (Reverse)

APPENDIX A (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code)
Channels	OTAG (CAMP-SB) P.O. Box 214405 Sacramento, CA 95821-0405	40th Personnel Svc Company 440 Arden Way Sacramento, CA 95828-0000

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
LOVE, Larissa M.	124-00-0081	SSG

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
40th Personnel Service Company Sacramento, CA	23 Apr 89	Camp Roberts, CA

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☒ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL

7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☒ MILITARY: Camp Roberts, TMC

8. HOUR AND DATE ADMITTED: N/A

9. HOUR AND DATE EXAMINED: 0700 23 Apr 89

10. DIAGNOSIS AND EXTENT OF ☒ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain): Irritation to Right eye

11. MEDICAL OPINION: a. INDIVIDUAL ☒ WAS ☐ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):
b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).
c. INJURY OR DISEASE ☐ IS ☒ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.
d. INJURY OR DISEASE ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).
e. CONDITION ☐ DID ☒ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☒ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT: ☒ NONE ESTIMATE OF TIME LOSS (Days): ☐ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL

13. BLOOD ALCOHOL TEST MADE ☐ YES ☒ NO

14. NO. OF MG ALCOHOL/100 ML BLOOD: N/A

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (How, where, when): Sm was enroute to place of duty and due to high winds, a foreign object blew into her right eye causing minor irritation.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
23 Apr 89	JOHN G. SMITH, MD	John G. Smith, MD

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS: ☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE

20. HOUR AND DATE OF ABSENCE: a. FROM: b. TO:

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) ☐ YES ☐ NO

22. INDIVIDUAL WAS ON ☐ ACTIVE DUTY ☒ ACTIVE DUTY FOR TRAINING 32 USC 503 ☐ INACTIVE DUTY TRAINING

23. HOUR AND DATE OF TRAINING: a. BEGAN 0700 22 Apr 89 b. END 2400 6 May 89

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed): SSG Love was enroute to her duty station on 23 Apr 89, when an object blew into her right eye causing irritation. Because her duty station was beyond the TMC, she stopped and received treatment for her eye. There was no witness to the incident and SSG Love was returned to duty the same day. No misconduct was involved.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☒ NO

32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☒ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE
23 Apr 89	GEORGE G. SCOTT, MAJ, CDR	George G. Scott, MAJ

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX A (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below.

(to be completed by unit prior to submission to physician)

Normal military duties for: 71L30 Administrative
(Service member's MOS)

Consist of the following Typing, filing and various other office requirements for administrative assistances

I have examined SSG Love, Larissa M. 124-00-0081 on 23 Apr 89
(Name and SSN) (Date)

Disabled from N/A (Date) to N/A (Date).

Date expected to return to normal military duty: 23 Apr 89
(without limitation)

Cause of disability: Right eye irritation
(Final Diagnosis)

Type medical treatment furnished: flushed eye with a mild solution, placed eye medication in

Nature of healing process (prognosis): Good - all irritation should be gone within one day

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes ____ no ____ no further treatment needed

This individual (is)* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual (has)* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: ____

Current medical profile: (by service physician)

P	U	L	H	E	S

23 Apr 89
(Date Signed)

John G. Smith
(Physician's Signature)

JOHN G. SMITH, MD
LIC# 245908
Camp Roberts TMC
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319; 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY. Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

APPENDIX A (continued)

(Battalion or Squadron Letterhead)

(date)

SUBJECT: TRAVEL ORDERS AND AUTHORIZATION FOR TREATMENT

TO: MEDICAL TREATMENT FACILITY, ATTN: PATIENT ADMINISTRATION
THE ADJUTANT GENERAL, CALIFORNIA NATIONAL GUARD, ATTN: CAMP-SB
UNITED STATES PROPERTY and FISCAL OFFICER for CALIFORNIA, ATTN: CAUS-TR
TRANSPORTATION OFFICER
Individual Concerned

1. The following member of the California Army National Guard is authorized medical care under the provisions of para 6, NGR 40-3, and para 4-2, AR 40-3 and is ordered to report for treatment as indicated:

(Last Name, First Name, MI., SSN, Rank, Unit, Unit Address and ZIP Code)

Attached to: _____
(Name, Address and ZIP Code of Medical Treatment Facility)

Reporting Date: _____ Period _____

Purpose: ☐ Treatment ☐ Evaluation ☐ Remedial Surgery ☐ MEB ☐ PEB

Additional instructions: Report to Patient Administration for an appointment in _____ at _____ hours
(allow 15 minutes for processing) (Clinic or Room)
If desired, Transportation Officer will furnish transportation request and meal tickets. Memorandum copy of transportation request and meal tickets will be forwarded to United States Property and Fiscal Officer for California, Camp San Luis Obispo, CA 93403-8660. Travel of dependents and mileage or monetary allowances are not authorized. Reimbursement for actual expenses is authorized. JTR Vol 1, 6005.

FOR ARNG/ARMY USE

AUTH: ☐ 32 USC 318; 37 USC 204(h) For all injuries incurred in line of duty. Also for diseases incurred in line of duty while under orders not specifying 30 days or less.

☐ 32 USC 319; For diseases incurred in line of duty while under orders specifying 30 days or less. Do not use for diseases incurred during inactive duty training.

Accounting classification: FY 89 Tvl, (Off) 2192060 18-1004 P2U21.1000 (211J,219J) _____ /BF0 S04376, (Enl) 2192060 18-1004 P2U41.1100 (211J,219J) _____ /BF0 S04376. (NOTE: Enter UIC in blank for officer or enlisted accounting classification.)

HOR _____
FORMAT 445

2. Background and status at time of injury/disease are as follows:

Type duty being performed: ☐ IDT ☐ AT ☐ FTTD ☐ REP TRNG ☐ OTHER

Inclusive dates of training: _____

Location where disease or injury occurred: _____

Date of occurrence: _____ Diagnosis: _____

Line of Duty Status: _____ Events leading to incident: _____

_____

3. Request treatment facility complete CAL ARNG Form 40-6-2. If a DA Form 2173 or CAL ARNG Provisional Form 2173 is inclosed, request Section I of that form also be completed. These two forms should be returned to this headquarters along with any civilian medical bills.

FOR THE COMMANDER:

(Signature and signature block of Adjutant)

CAL ARNG Form 40-6-1 **1 Nov 88** **(Replaces CAL ARNG Form 40-6-1 dated 17 Feb 88)**

APPENDIX A (continued)

STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
P.O. Box 214405 - 2829 Watt Avenue
Sacramento, California 95821-4405

PERMANENT ORDERS 62-13 4 November 1988

HHC 1st Bde 40th Inf Div
HHC 2d Bn 160th Inf
Det 1 HHC 2d Bn 160th Inf
Co A 2d Bn 160th Inf
Co B 2d Bn 160th Inf
Co C 2d Bn 160th Inf
Co D 2d Bn 160th Inf
Det 1 Co D 2d Bn 160th Inf
Co E 2d Bn 160th Inf
HHC 3d Bn 160th Inf
Co A 3d Bn 160th Inf
Co B 3d Bn 160th Inf
Co C 3d Bn 160th Inf
Co D 3d Bn 160th Inf
Co E 3d Bn 160th Inf
HHC 1st Bn 185th Armor
Co A 1st Bn 185th Armor
Co B 1st Bn 185th Armor
Co C 1st Bn 185th Armor
Co D 1st Bn 185th Armor
HHB 2d Bn 144th FA
Btry A 2d Bn 144th FA
Btry B 2d Bn 144th FA
Btry C 2d Bn 144th FA
Svc Btry 2d Bn 144th FA
HHD 40th Spt Bn
Co A 40th Spt Bn
Co B 40th Spt Bn
Co C 40th Spt Bn
Det 2 Co A 132d Engr Bn
40th Pers Svc Co

The Army National Guard unit shown and its members are ordered to annual training for the period indicated and will proceed from home station to duty station shown. Upon completion of annual training, return to home station and terminate annual training status.

Authority: NGB Training Authority CA-11 FY 89, 32 USC 503 and Sections 142 and 368 California Military and Veterans Code
Duty station: Camp Roberts CA
Period: 22 Apr - 6 May 89 (15 days including travel time) TDC: 101
Accounting classification: Off Pay & alw 2192060 18-1004 P1A10.1000-1100,1200 S04376
Off Tvl & PD 2192060 18-1004 P1A50.1000-2100 S04376
EM Pay & alw 2192060 18-1004 P1A30.1100-1100,1200 S04376
EM Tvl & PD 2192060 18-1004 P1A60.1100-2100 S04376
Additional instructions: Payrolls will be accomplished in accordance with instructions contained in CAL ARNGR 350-5. Units are authorized group travel by commercial charter bus if appropriate. Accounting classification:

APPENDIX B

TRANSMITTAL FORM

The proponent of this form is CAMP-SB. See CAL PAM 40-2 for complete instructions.

☒ Line of Duty ☐ Incapacitation ☐ Death ☐ Medical Bills ☐ Other

Office of the Adjutant General State Military Forces ATTN: CAMP-SB P. O. Box 214405 Sacramento, CA 95821-0405	From: HHB, 2d Bn 144th FA 260th W. Huntington Drive Arcadia, CA 91006-3401

Date: 8 May 89	POC: SGT Tirzah Bond, Unit Clerk	Phone: (818) 447-1147

USAGE: All source documents sent to Support Branch are logged in and out to provide control at all levels and to furnish an audit trail.

INSTRUCTIONS TO COMPLETE FORM: Check-off inventory items attached and obtain signature of BN or MACOM Administrative Officer (AO). Forward to OTAG, ATTN: CAMP—SB Box #20. Special Instructions are provided on the reverse side of this form. See CAL PAM 40-2 for complete instructions.

SOLDIER'S NAME: DOE, John J. PFC SSN: 001-22-0345 DOI: 23 Apr 89

DOCUMENT INVENTORY FOR LOD:

INFORMAL LOD

- ☒ CAL ARNG Form 40-2
- ☒ CAL ARNG Form 2173
- ☒ Injured Soldier's Statement (DD Form 2823) #1
- ☒ Witness Statement(s) (DD Form 2823) #1
- ☒ Medical Treatment Records (CAL NG Form 40-6-2) #8
- ☒ AT Orders/IDT Training Schedule #6
- ☐ Other Documents #2

ADMINISTRATIVE LOD

- ☐ CAL ARNG Form 40-2
- ☐ CAL ARNG Form 2173

FORMAL LOD

- ☐ CAL ARNG Form 40-2
- ☐ DD Form 261
- ☐ Order Appointing Investigating Officer.
- ☐ CAL ARNG Form 2173
- ☐ Letter of Adverse Personnel Action #7
- ☐ Injured Soldier's Statement (DD Form 2823) #1
- ☐ Witness Statement(s) (DD Form 2823) #1
- ☐ Medical Treatment Records (CAL NG Form 40-6-2)
- ☐ DA Form 3881 Rights Warning #3
- ☐ Accident/Police Report #4
- ☐ Map (showing direct route) (As Required)
- ☐ AT Orders/IDT Training Schedule #6

See special instructions.
(Refer to reverse side for INCAP and DEATH inventory)

Administrative Officer Certification:

I certify that I have personally reviewed the attached documents and found them to be correct and complete in accordance to CAL PAM 40-2.

13 May 1989
DATE OF CERTIFICATION

Charles T. Travis/MAJ Charles Travis
PRINT/TYPE NAME/RANK AND SIGNATURE

CAL ARNG Form 40-2

APPENDIX B (continued)

INCAPACITATION PAYROLL

1. Initial Payroll:

- ☐ CAL ARNG Form 40-2
- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2/Doctors Statement
- ☐ CAL NG Form 37-D
- ☐ CAL ARNG Form 2173, with approval
- ☐ DA Form 261, with approval
- ☐ AT Order/IDT Training Schedule

2. Additional Payrolls

- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2 #8

DEATH CASE

- ☐ CAL ARNG Form 40-2
- ☐ Death Report Example AR 10-7 para 10-7
- ☐ Certified Death Cert.
- ☐ DD Form 93
- ☐ VA Form 29-8286
- ☐ Last three LES
- ☐ MPRJ File #5
- ☐ Statement of pay due
- ☐ Unit Training Schedule #6
- ☐ Police Report*
- ☐ Coroner Report*

*Depending on the cause of death (gun shot wound, auto accident, etc).

SPECIAL INSTRUCTIONS

1. DD Form 2823 should be used if available.Plain bond or notebook paper can be substituted.
2. Submit other documents as required to assist in the investigation/determination. (physicals, accident reports, maps, etc).
3. Rights warning are required only if soldier is suspected or accused of any offense under the UCMJ.
4. Accident/police report are required if a vehicle accident is directly related.
5. Forward MPRJ unless stored at CAMP-CARE. (Indicate MPRJ's location in comments.)
6. AT Orders/IDT training Schedule are required when on duty status.
7. Letter of notification for not-in-line-of-duty findings and adverse personnel action pending.
8. CAL ARNG Form 40-6-2 must be submitted with each INCAP payroll request. A doctor's medical statement can be substituted in place of the CAL ARNG Form 40-6-2.

COMMENTS:

CAL ARNG Form 40-2 (26 Mar 90) (Reverse)

APPENDIX B (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code) (818)447-1144
CHANNELS	OTAG (CAMP-SB) P.O. Box 214405 Sacramento, CA 95821-0405	HHB 2d Bn 144th FA 260th W. Huntington Drive Arcadia, CA 91006-3401

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
DOE, John J.	001-22-0345	PFC

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
HHB, 2d Bn 144th FA Arcadia, CA	23 Apr 89	Camp Roberts, CA

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☒ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL	7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☒ MILITARY
	Silas B. Hayes ACH, Ft. Ord, CA
8. HOUR AND DATE ADMITTED: N/A	9. HOUR AND DATE EXAMINED: 1530 23 Apr 89

10. DIAGNOSIS AND EXTENT OF ☒ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain)
Sprained Right Wrist

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☒ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):
b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).
c. INJURY OR DISEASE ☒ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.
d. INJURY OR DISEASE ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).
e. CONDITION ☐ DID ☒ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☒ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT ☐ NONE ESTIMATE OF TIME LOSS (Days): ☒ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL	13. BLOOD ALCOHOL TEST MADE ☐ YES ☐ NO	14. NO. OF MG ALCOHOL/100 ML BLOOD N/A

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (How, where, when)
Around 1445 hours, 23 Apr 89, PFC Doe was assisting in field artillery hasty displacement at firing point 20. He fell while loading M577 and sprained his right wrist.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
23 Apr 89	John Q. Smith, MAJ, MD	John Q. Smith, MAJ, MC

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS ☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY ☐ ON PASS ☐ ON LEAVE	20. HOUR AND DATE OF ABSENCE a. FROM: N/A	b. TO: N/A

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance)
☐ YES ☐ NO

22. INDIVIDUAL WAS ON ☐ ACTIVE DUTY ☒ ACTIVE DUTY FOR TRAINING ☐ INACTIVE DUTY TRAINING	23. HOUR AND DATE OF TRAINING a. BEGAN: 0600 22 Apr 89	b. END: 1700 6 May 89

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL
N/A	N/A	N/A	N/A

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).
PFC Doe was loading a M577 Command Carrier for hasty displacement from firing point 20 Camp Roberts, CA. During the loading, PFC Doe slipped and fell from the top of the M577, landing on his right side and wrist. SM was evacuated to the Camp Roberts TMC, where it was determined that his right wrist was sprained. IN LINE OF DUTY.
SSG Paul W. Spencer, 987-65-4321, witnessed this accident. Address unknown.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☒ NO	32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☒ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE
23 April 1989	CURTIS M. KELLEY, CPT, FA, CDR	Curtis M. Kelley, CPT

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX B (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER
Camp Roberts, CA	23 Apr 89	1600 hrs	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
DOE, John Jay	001-22-0345	PFC

ORGANIZATION OR ADDRESS
HHB, 2d Bn 144th FA, 260th W. Huntington Drive, Arcadia, CA 91006-3401

I, John J. Doe, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:
on 23 Apr 89, at 1445 hours, I was putting my personal gear on the M577 Command Carrier (APC) for a hasty displacement exercise from firing point 20, Camp Roberts, CA. I was carrying two ruck sacks (one on my back and one over my left shoulder) and I was climbing on the top of the M577 to put my gear in the hatch. While climbing up, I lost my footing and slipped and fell from the top to the ground. I fell on my right side and twisted my right wrist trying to break my fall. I have had no previous injury to my right wrist. SSG Spencer was standing near where I landed and called for help. I was transported to the Camp Roberts TMC. END OF STATEMENT

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 1 JUL 72 2823 SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

APPENDIX B (continued)

STATEMENT (Continued)

AFFIDAVIT

I, John J. Doe HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 1. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

John J. Doe
(Signature of Person Making Statement)

WITNESSES:

JOHN G. DOUGH
CPT, IN, CAARNG
Investigating Officer
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 23 day of April, 1989 at Camp Roberts, CA

John G. Dough
(Signature of Person Administering Oath)

JOHN G. DOUGH
(Typed Name of Person Administering Oath)

ORGANIZATION OR ADDRESS

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE 2 OF 2 PAGES

APPENDIX B (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER
Camp Roberts, CA	23 Apr 89	1600 hrs	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
SPENCER, Paul William	987-65-4321	SSG/E6

ORGANIZATION OR ADDRESS
HHB, 2d Bn 144th FA, 260th W. Huntington Drive, Arcadia, CA 91006-3401

I, Paul W. Spencer, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

On 23 Apr 89 at 1445, I was standing by the M577 Command Carrier (APC) supervising the loading of personal gear for a Hasty Displacement exercise from firing point 20, Camp Roberts, CA. PFC Doe was carrying two ruck sacks to load throught the top hatch. He attempted to climb up to the top hatch and lost his footing and fell to the ground. He stated his right wrist was hurt and I summoned help and PFC Doe was transported to Camp Roberts TMC. There was not misconduct involved. END OF STATMENT

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES
	PWS	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 2823, 1 JUL 72 SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

APPENDIX B (continued)

STATEMENT (Continued)

AFFIDAVIT

I, Paul W. Spencer HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 1. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

Paul W. Spencer
(Signature of Person Making Statement)

WITNESSES:

JOHN G. DOUGH
CPT, IN, CAARNG
Investigating Officer
ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 23 day of Apr, 19 89 at Camp Roberts, CA

John G. Dough
(Signature of Person Administering Oath)

JOHN G. DOUGH
(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE OF PAGES

APPENDIX B (continued)

INDIVIDUAL SICK SLIP
☐ ILLNESS ☒ INJURY

DATE: 23 Apr 89

LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT: Doe, John J.

SERVICE NUMBER/SSN: 001-22-0345

GRADE/RATE: PFC / E3

ORGANIZATION AND STATION: HHB, 2/144th FA
260 W. Huntington Drive
ARcadia, CA 91006-3401

UNIT COMMANDER'S SECTION

IN LINE OF DUTY: Yes

REMARKS: possible broken (R) WRist — fell off M577 Command Carrier and hurt (R) side and (R) WRist

SIGNATURE OF UNIT COMMANDER: Curtis M Kelley, CPT, FA, Cdr

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY: Yes

DISPOSITION OF PATIENT: ☐ DUTY ☐ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☒ OTHER (Specify):

REMARKS: transport to MTF at FT. ORd for X-RAY

SIGNATURE OF MEDICAL OFFICER: Adolfo C. Coussirat, MD

DD FORM 1 MAR 68 689 PREVIOUS EDITIONS ARE OBSOLETE.

APPENDIX B (continued)

600-108

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
23 Apr 89 B/P 124/88 WT 208 T 97.3	PT C/O right wrist pain states injury occured when he fell off an APC while on A/D Status SSG Bonnie Woodward, 91C
	Poss FX of (R) wrist TRANSPORT TO MTF Fort ORD Adolfo C. Coussirat, M.D.

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

RECORDS MAINTAINED AT:

PATIENT'S NAME (*Last, First, Middle initial*) DOE, JOHN J	SEX M
RELATIONSHIP TO SPONSOR / STATUS	RANK/GRADE PFC/E3
SPONSOR'S NAME	ORGANIZATION HHB 2/144 FA
DEPART./SERVICE CA ARNG / SSN/IDENTIFICATION NO 001-22-0345	DATE OF BIRTH 966Sep4

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

APPENDIX B (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below:

(to be completed by unit prior to submission to physician)

Normal military duties for: 13F10 Fire Support Specialist
(Service member's MOS)

Consist of the following Be able to walk, run, squat, crawl and fire a weapon.

Be totally able to work with no restrictions in a field environment.

I have examined PFC John J. Doe, 001-22-0345 on 23 April 1989
(Name and SSN) (Date)

Disabled from 23 April 1989 (Date) to 20 MAY 1989 (Date)

Date expected to return to normal military duty: 21 May 1989
(without limitation)

Cause of disability: Right Wrist Sprain
(Final Diagnosis)

Type medical treatment furnished: Splint, anti-inflammatory medication, limited duty, ice & elevate in evenings

Nature of healing process (prognosis): Good - Full Recovery expected - Return To Full Duty 4 weeks.

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes X no ____

This individual ~~(is)~~* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual ~~(has)~~* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: N/A

Current medical profile: (by service physician)

P	U	L	H	E	S
1	T3	1	1	1	1

John Q. Smith, MAJ, MC
(Physician's Signature)

23 April 1989
(Date Signed)

John Q. Smith, MAJ, MC
LIC # 28460921
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319; 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY: Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 **Replaces CAL ARNG Form 40-6-2 17 Feb 88**

APPENDIX B (continued)

STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
P.O. Box 214405 - 2829 Watt Avenue
Sacramento, California 95821-4405

PERMANENT ORDERS 62-13 4 November 1988

HHC 1st Bde 40th Inf Div
HHC 2d Bn 160th Inf
Det 1 HHC 2d Bn 160th Inf
Co A 2d Bn 160th Inf
Co B 2d Bn 160th Inf
Co C 2d Bn 160th Inf
Co D 2d Bn 160th Inf
Det 1 Co D 2d Bn 160th Inf
Co E 2d Bn 160th Inf
HHC 3d Bn 160th Inf
Co A 3d Bn 160th Inf
Co B 3d Bn 160th Inf
Co C 3d Bn 160th Inf
Co D 3d Bn 160th Inf
Co E 3d Bn 160th Inf
HHC 1st Bn 185th Armor
Co A 1st Bn 185th Armor
Co B 1st Bn 185th Armor
Co C 1st Bn 185th Armor
Co D 1st Bn 185th Armor
HHB 2d Bn 144th FA
Btry A 2d Bn 144th FA
Btry B 2d Bn 144th FA
Btry C 2d Bn 144th FA
Svc Btry 2d Bn 144th FA
HHD 40th Spt Bn
Co A 40th Spt Bn
Co B 40th Spt Bn
Co C 40th Spt Bn
Det 2 Co A 132d Engr Bn
40th Pers Svc Co

The Army National Guard unit shown and its members are ordered to annual training for the period indicated and will proceed from home station to duty station shown. Upon completion of annual training, return to home station and terminate annual training status.

Authority: NGB Training Authority CA-11 FY 89, 32 USC 503 and Sections 142 and 368 California Military and Veterans Code
Duty station: Camp Roberts CA
Period: 22 Apr - 6 May 89 (15 days including travel time) TDC: 101
Accounting classification: Off Pay & alw 2192060 18-1004 P1A10.1000-1100,1200 S04376
Off Tvl & PD 2192060 18-1004 P1A50.1000-2100 S04376
EM Pay & alw 2192060 18-1004 P1A30.1100-1100,1200 S04376
EM Tvl & PD 2192060 18-1004 P1A60.1100-2100 S04376
Additional instructions: Payrolls will be accomplished in accordance with instructions contained in CAL ARNGR 350-5. Units are authorized group travel by commercial charter bus if appropriate. Accounting classification:

APPENDIX C

TRANSMITTAL FORM

The proponent of this form is CAMP-SB. See CAL PAM 40-2 for complete instructions.

☒ Line of Duty ☐ Incapacitation ☐ Death ☐ Medical Bills ☐ Other

Office of the Adjutant General
State Military Forces
ATTN: CAMP-SB
P. O. Box 214405
Sacramento, CA 95821-0405

From: HHC, 40th Inf Div (M)
2876 E. Vendor Street
Los Alamitos, CA 90720-5001

Date: 28 July 1989 | POC: CPT Henry Doe | Phone: (213) 493-8475

USAGE: All source documents sent to Support Branch are logged in and out to provide control at all levels and to furnish an audit trail.

INSTRUCTIONS TO COMPLETE FORM: Check-off inventory items attached and obtain signature of BN or MACOM Administrative Officer (AO). Forward to OTAG, ATTN: CAMP—SB Box #20. Special Instructions are provided on the reverse side of this form. See CAL PAM 40-2 for complete instructions.

SOLDIER'S NAME: MSG JEFFERSON, George C. SSN: 123-45-6789 DOI: 16 Jun 89

DOCUMENT INVENTORY FOR LOD:

INFORMAL LOD

- ☐ CAL ARNG Form 40-2
- ☐ CAL ARNG Form 2173
- ☐ Injured Soldier's Statement (DD Form 2823) #1
- ☐ Witness Statement(s) (DD Form 2823) #1
- ☐ Medical Treatment Records (CAL NG Form 40-6-2) #8
- ☐ AT Orders/IDT Training Schedule #6
- ☐ Other Documents #2

ADMINISTRATIVE LOD

- ☐ CAL ARNG Form 40-2
- ☐ CAL ARNG Form 2173

FORMAL LOD

- ☒ CAL ARNG Form 40-2
- ☒ DD Form 261
- ☒ Order Appointing Investigating Officer.
- ☒ CAL ARNG Form 2173
- ☐ Letter of Adverse Personnel Action #7
- ☒ Injured Soldier's Statement (DD Form 2823) #1
- ☒ Witness Statement(s) (DD Form 2823) #1
- ☒ Medical Treatment Records (CAL NG Form 40-6-2)
- NA ☒ DA Form 3881 Rights Warning #3
- NA ☒ Accident/Police Report #4
- NA ☒ Map (showing direct route) (As Required)
- ☒ AT Orders/IDT Training Schedule #6

See special instructions.
(Refer to reverse side for INCAP and DEATH inventory)

Administrative Officer Certification:

I certify that I have personally reviewed the attached documents and found them to be correct and complete in accordance to CAL PAM 40-2.

28 July 1989
DATE OF CERTIFICATION

DOE, HENRY/CPT Henry Doe
PRINT/TYPE NAME/RANK AND SIGNATURE

CAL ARNG Form 40-2

APPENDIX C (continued)

INCAPACITATION PAYROLL

1. Initial Payroll:

- ☐ CAL ARNG Form 40-2
- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2/Doctors Statement
- ☐ CAL NG Form 37-D
- ☐ CAL ARNG Form 2173, with approval
- ☐ DA Form 261, with approval
- ☐ AT Order/IDT Training Schedule

2. Additional Payrolls

- ☐ CAL NG Form 37-2C
- ☐ CAL ARNG Form 37-9
- ☐ CAL NG Form 37-2H
- ☐ CAL NG Form 37-2E (If required)
- ☐ CAL NG Form 37-2F (If required)
- ☐ Check Stub (If required)
- ☐ CAL ARNG Form 40-6-2 #8

DEATH CASE

- ☐ CAL ARNG Form 40-2
- ☐ Death Report Example AR 10-7 para 10-7
- ☐ Certified Death Cert.
- ☐ DD Form 93
- ☐ VA Form 29-8286
- ☐ Last three LES
- ☐ MPRJ File #5
- ☐ Statement of pay due
- ☐ Unit Training Schedule #6
- ☐ Police Report*
- ☐ Coroner Report*

*Depending on the cause of death (gun shot wound, auto accident, etc).

SPECIAL INSTRUCTIONS

1. DD Form 2823 should be used if available.Plain bond or notebook paper can be substituted.
2. Submit other documents as required to assist in the investigation/determination. (physicals, accident reports, maps, etc).
3. Rights warning are required only if soldier is suspected or accused of any offense under the UCMJ.
4. Accident/police report are required if a vehicle accident is directly related.
5. Forward MPRJ unless stored at CAMP-CARE. (Indicate MPRJ's location in comments.)
6. AT Orders/IDT training Schedule are required when on duty status.
7. Letter of notification for not-in-line-of-duty findings and adverse personnel action pending.
8. CAL ARNG Form 40-6-2 must be submitted with each INCAP payroll request. A doctor's medical statement can be substituted in place of the CAL ARNG Form 40-6-2.

COMMENTS:

CAL ARNG Form 40-2 (26 Mar 90) (Reverse)

APPENDIX C (continued)

REPORT OF INVESTIGATION
LINE OF DUTY AND MISCONDUCT STATUS
(AR 600-10 or AFR 35-67)

DATE: 27 June 89

1 INVESTIGATION OF: ☐ INJURY ☒ DISEASE ☐ DEATH

2 TO: *(Major Army or Air Force Commander)* Chief National Guard Bureau, Washington D.C., 20310-2500

3 STATUS
a. ☐ REGULAR OR EAD
b. CALLED OR ORDERED TO AD FOR (1) ☐ MORE THAN 30 DAYS (2) ☐ 30 DAYS OR LESS
c. ☐ INACTIVE DUTY TRAINING (Type)
d. ☒ SHORT TOUR OF ACTIVE DUTY FOR TRAINING 32 USC 503

4 LAST NAME - FIRST NAME - MIDDLE INITIAL	5. SERVICE NO. SSAN	6 GRADE
JEFFERSON, George C.	123-45-6789	MSG/E8

7 ORGANIZATION AND STATION OF INDIVIDUAL: HHC, 40th Infantry Division (M), Los Alamitos, CA 90720-5001

8 OTHER MILITARY PERSONNEL INVOLVED IN THE SAME INCIDENT (Last Name - First Name - Middle Initial)	SERVICE NUMBER OR SSAN	GRADE	LOD INVESTIGATION MADE YES	LOD INVESTIGATION MADE NO
NONE				

DURATION *(Applies ONLY to 3c and 3d)*

	DATE	HOUR
START	10Jun89	0600
FINISH	24Jun89	1700

9 BASIS FOR FINDINGS *(As determined by investigation)*

a. CIRCUMSTANCES: (1) HOUR: 1200; (2) DATE: 16 Jun 89; (3) PLACE: Camp Roberts, CA 93451-5000

(4) HOW SUSTAINED: Stress while working in 97+ degree weather.

b. MEDICAL DIAGNOSIS: Acute Myocardial Infarcation

c. ☒ WAS ☐ WAS NOT PRESENT FOR DUTY

d. ABSENT ☐ WITH ☐ WITHOUT AUTHORITY

(Do not complete e and f in death cases)
e. INTENTIONAL MISCONDUCT OR NEGLECT ☐ WAS ☒ WAS NOT THE PROXIMATE CAUSE

f. ☒ WAS ☐ WAS NOT MENTALLY SOUND

g. REMARKS: MSG JEFFERSON was walking with SPC Michaels to the mess area for lunch. He began to experience severe chest pains and shortness of breath. SPC Michaels summoned help and MSG Jefferson was taken to Twin Cities Comm Hospital. There is no particular incident that can be singled out as having caused the heart attack. The fact that MSG Jefferson was acting 1SG (a position he had never held before), the in-the-field environment under simulated combat conditions coupled with the hot weather were all contributing factors.

10 FINDINGS *(Do not complete in death cases)*
☒ IN LINE OF DUTY
☐ NOT IN LINE OF DUTY - NOT DUE TO OWN MISCONDUCT
☐ NOT IN LINE OF DUTY - DUE TO OWN MISCONDUCT

ORGANIZATION AND STATION OF INVESTIGATING OFFICER: HHC, 40th Inf Div (M), Los Alamitos, CA

SIGNATURE AND TYPED NAME OF INVESTIGATING OFFICER: JOHN G. DOUGH, JR. John G. Dough Jr.

GRADE	BRANCH	SERVICE NO./SSAN
03/CPT	IN	222-33-4444

ACTION BY APPOINTING AUTHORITY

HEADQUARTERS: HQ, 40th Inf Div (M) DATE: 30 Jun 89

☒ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME: PETER B. PRINCIPLE Peter B. Principle

GRADE	BRANCH	SERVICE NO./SSAN
CW4		333-44-5555

ACTION BY REVIEWING AUTHORITY

HEADQUARTERS: OTAG, Sacramento, CA DATE: 12 Jul 89

☒ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME: THOMAS T. TYLER Thomas T. Tyler

GRADE	BRANCH	SERVICE NO. SSAN
04/MAJ	IN	444-55-6666

FOR ACTION OF OFFICE INDICATED IN ITEM 2

DD FORM 1 OCT 88 261 REPLACES EDITION OF 1 AUG 88. EXISTING SUPPLIES OF WHICH WILL BE USED UNTIL EXHAUSTED

APPENDIX C (continued)

CADH-AP-PA 23 June 1989

MEMORANDUM FOR: CPT John G. Dough, Jr., 222-33-4444, HHC 40th Inf Div (M)

SUBJECT: Appointment of Investigating Officer Formal LOD Pertaining to: MSG George C. JEFFERSON, 123-45-6789.

1. Effective 23 June 1989, CPT John G. Dough, Jr., 222-33-4444, is appointed as an Investigating Officer.

2. Authority: AR 600-8-1, NGR 600-3.

3. Purpose: To perform a Line of Duty Investigation IAW AR 600-8-1, NGR 600-3, obtaining the details pertaining to the heart attack of MSG George C. Jefferson, 123-45-6789, HHC, 40th Inf Div (M) that occured at Camp Roberts, CA on 16 June 89.

4. Period: Until the investigation is completed and no further investigation is required, unless released sooner by the appointing authority.

5. Special Instructions: Conduct of this investigation will be your primary duty until the investigation is submitted to the appointing authority. Your findings will be supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. Your report of investigation will be submitted to this Headquarters NLT 30 June 1989.

FOR THE COMMANDER:

PETER B. PRINCIPLE
CW4, CA ARNG
Asst AG

APPENDIX C (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code) (213)493-8475
CHANNELS	OTAG (CAMP-SB) P.O. Box 214405 Sacramento, CA 95821-0405	HHC, 40th Inf Div (M) 2876 E. Vendor Street Los Alamitos, CA 90720-5001

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
JEFFERSON, George C.	123-45-6789	MSG/E8

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
HHC, 40th Inf Div (M) Los Alamitos, CA 90720-5001	16 Jun 89	Camp Roberts, CA

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☐ OUT PATIENT ☒ ADMITTED ☐ DEAD ON ARRIVAL	7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☐ MILITARY
	Twin Cities Community Hospital, Templeton, CA

8. HOUR AND DATE ADMITTED	9. HOUR AND DATE EXAMINED
1245 16 Jun 89	1245 16 Jun 89

10. DIAGNOSIS AND EXTENT OF ☐ INJURY ☒ DISEASE ☐ RESULTING IN DEATH (Explain)
Acute Myocardial Infarction

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☒ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):
b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).
c. INJURY OR DISEASE ☒ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.
d. INJURY OR DISEASE ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in Item 15).
e. CONDITION ☒ DID ☐ DID NOT EXIST PRIOR TO SERVICE AND ☒ WAS ☐ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT ☐ NONE ESTIMATE OF TIME LOSS (Days): ☐ TEMPORARY ☐ PERMANENT PARTIAL ☒ PERMANENT TOTAL	13. BLOOD ALCOHOL TEST MADE ☐ YES ☒ NO	14. NO. OF MG ALCOHOL/100 ML BLOOD
		N/A

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (How, where, when)
On 16 Jun 89 at approx 1200 hrs, patient c/o severe arm pain, nausea, developed into severe chest pain, dysnea and shortness of breath.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
16 Jun 89	Charles M. Masten, MD	Charles M. Masten MD

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS	20. HOUR AND DATE OF ABSENCE	
	a. FROM	b. TO
☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE	N/A	N/A

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) ☐ YES ☐ NO N/A

22. INDIVIDUAL WAS ON	23. HOUR AND DATE OF TRAINING	
	a. BEGAN	b. END
☐ ACTIVE DUTY ☒ ACTIVE DUTY FOR TRAINING 32 USC 503 ☐ INACTIVE DUTY TRAINING	0800 10 Jun 89	2400 24 Jun 89

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL
N/A	N/A	N/A	N/A

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).
MSG Jefferson, acting 1SG for HHC 40th Inf Div (M), was walking with SPC Michaels, SSN: 987-65-4321, when he began complaining of chest pains and had a a hard time breathing. The weather was very hot and MSG Jefferson was under a lot of pressure. He was taken to Twin Cities Community Hospital and admitted for a heart attack.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED	32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths)
☒ YES ☐ NO	☐ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE
17 Jun 89	MARY V. GREENWOOD, CPT, AG, Cdr	Mary V. Greenwood, CPT

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX C (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER
Camp Roberts, CA	17 Jun 89	0800	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
JEFFERSON, George C.	123-45-6789	MSG/E8

ORGANIZATION OR ADDRESS

HHC, 40th Infantry Division (M), Los Alamitos, CA 90720-5001

I, George C. Jefferson, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

At Annual Training 89, I was made 1SG because the 1SG had to leave AT early because of a family emergency at home. I have never been a 1SG before and I felt a lot of stress because I had so much to do. The weather was very hot. I was walking to get some lunch around 1200 hours with SPC Michaels and I felt as if I had lost all feeling in my arms and someone had just stuck a hot burning iron in my chest. I told SPC Michaels I could not walk anymore and I felt chest pains. He helped me to sit down on the ground and got help. I was taken to the civilian hospital. I never knew I had a bad heart condition. END OF STATEMENT

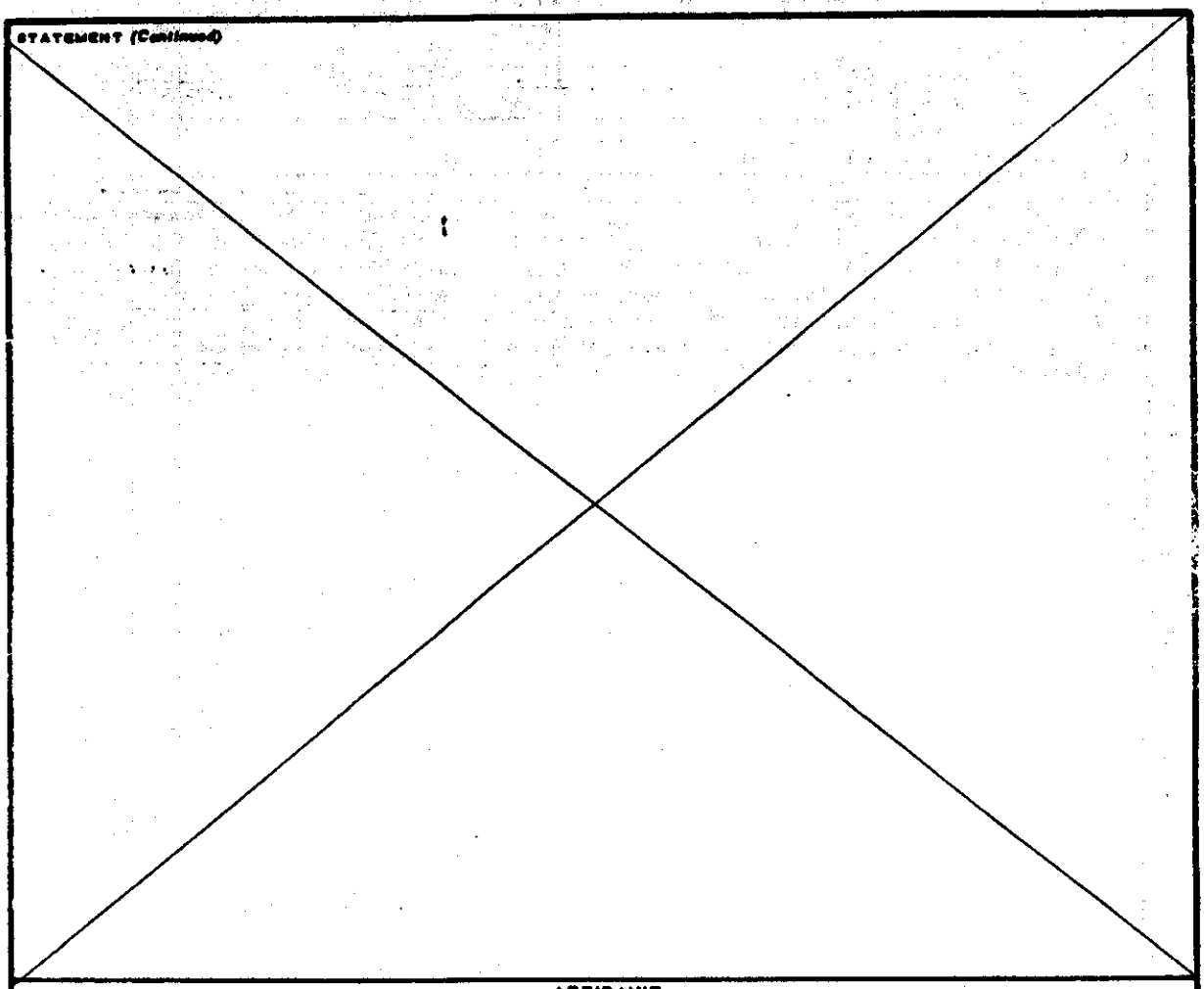
EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES
	GCJ	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 1 JUL 72 2823 SUPERSEDES DA FORM 2823, 1 JAN 69, WHICH WILL BE USED.

APPENDIX C (continued)

STATEMENT (Continued)



AFFIDAVIT

I, GEORGE C. JEFFERSON HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 1. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

George C. Jefferson, MSG
(Signature of Person Making Statement)

WITNESSES:

JOHN G. DOUGH
CPT, IN, CAARNG
Investigating Officer
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 17 day of June, 1989 at Twin Cities Community Hospital, CA

John G. Dough
(Signature of Person Administering Oath)

JOHN G. DOUGH
(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

ORGANIZATION OR ADDRESS

INITIALS OF PERSON MAKING STATEMENT

PAGE 2 OF 2 PAGES

☆ U.S. G.P.O. 1985-421-744/60551

APPENDIX C (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER
Camp Roberts, CA	18 Jun 89	1430	

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER	GRADE/STATUS
MICHAELS, Steven W.	987-65-4321	SPC/E4

ORGANIZATION OR ADDRESS

HHC, 40th Inf Div (M), Los Alamitos, CA 90720-5001

I, Steven W. Michaels, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

In the field at Annual Training 89 at Camp Roberts, CA while walking with the acting 1SG, MSG Jefferson to the mess tent for lunch. MSG Jefferson stopped and grabbed my arm and said he could not walk anymore he was having chest pains and his arm felted numb. I helped him to sit on the ground and got help. He was taken to the emergency room at a civilian hospital. I found out later he had had a heart attack. END OF STATEMENT.....

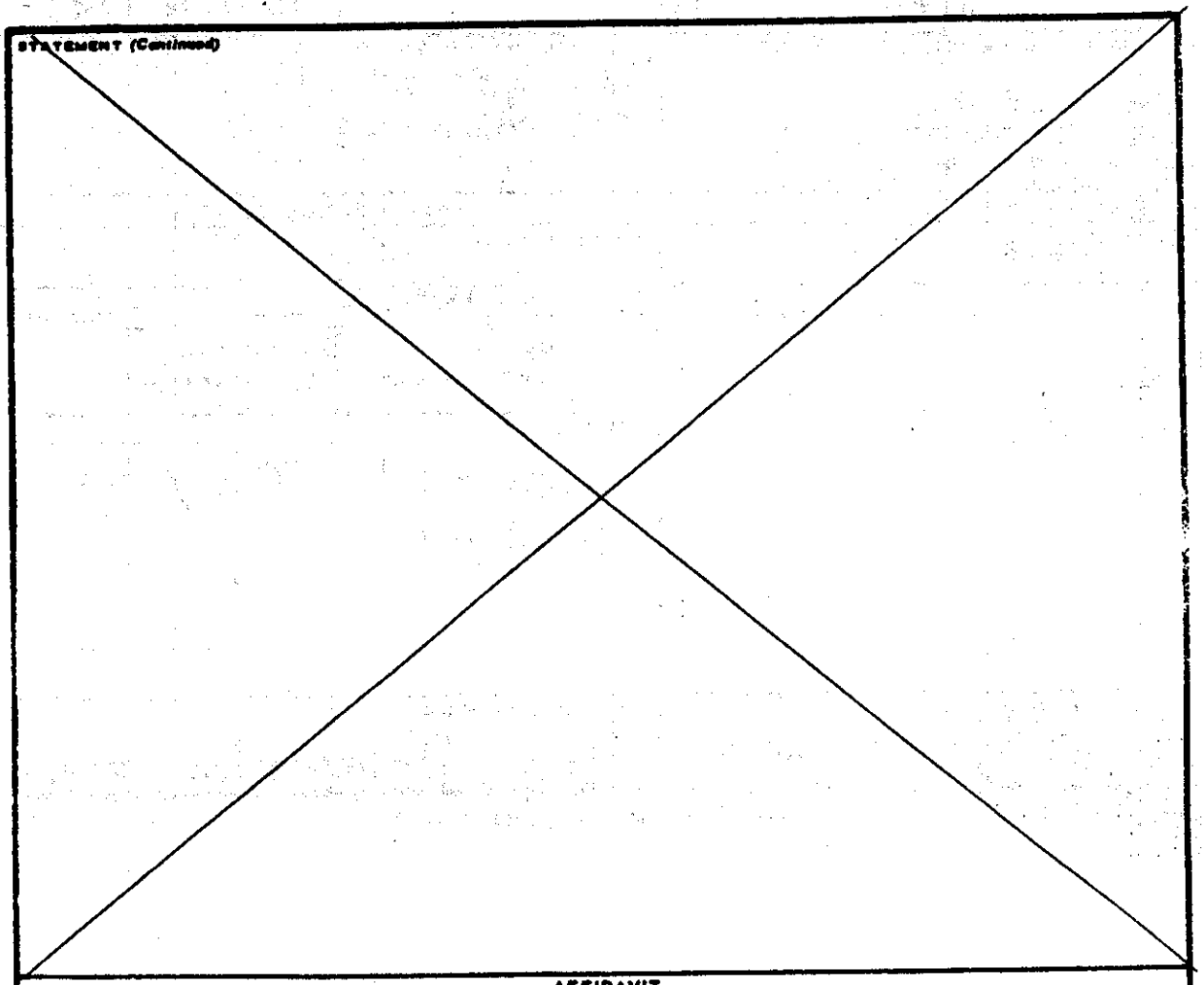
EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF 2 PAGES
	SWM	

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 1 JUL 72 2823 SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

APPENDIX C (continued)

STATEMENT (Continued)



AFFIDAVIT

I, Steven W. Michaels HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 1. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

Steven W. Michaels
(Signature of Person Making Statement)

WITNESSES:

JOHN G. DOUGH
CPT, IN, CAARNG
Investigating Officer
ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 18 day of June, 1989 at Camp Roberts, CA

John G. Dough
(Signature of Person Administering Oath)

JOHN G. DOUGH
(Typed Name of Person Administering Oath)

(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT

PAGE OF PAGES

DA FORM G.P.O. 1985-461-[illegible] 0150

APPENDIX C (continued)

INDIVIDUAL SICK SLIP
☒ ILLNESS ☐ INJURY

DATE: 16 JUN 1989

LAST NAME - FIRST NAME - MIDDLE INITIAL OF PATIENT: Jefferson, George C.

SERVICE NUMBER/SSN: 123-45-6789

GRADE/RATE: MSG/E8

ORGANIZATION AND STATION: HHC, 40th Inf DIV
Los Alamitos, CA

UNIT COMMANDER'S SECTION

IN LINE OF DUTY: Yes

REMARKS: Chest pain

SIGNATURE OF UNIT COMMANDER: Maria E. Leonhard, 1SG

MEDICAL OFFICER'S SECTION

IN LINE OF DUTY: Yes

DISPOSITION OF PATIENT
☐ DUTY ☐ QUARTERS
☐ SICK BAY ☒ HOSPITAL
☐ NOT EXAMINED ☐ OTHER (Specify):

REMARKS: Transport to TC Hosp via Ambulance

SIGNATURE OF MEDICAL OFFICER: Margie Morningstar, SPC, 91B

DD FORM 1 MAR 62 689 PREVIOUS EDITIONS ARE OBSOLETE.

APPENDIX C (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below.

(to be completed by unit prior to submission to physician)

Normal military duties for: 11B40 Infantryman
(Service member's MOS)

Consist of the following: A total field environment MOS requiring running, long road marches and various other strenous activities.

I have examined MSG Jefferson, George C. 123-45-6789 on 16 Jun 89
(Name and SSN) (Date)

Disabled from 16 JUN 89 (Date) to Undetermined (Date)

Date expected to return to normal military duty (without limitation): pending eval by Military Physician

Cause of disability: Acute Myocaedial Infarcation
(Final Diagnosis)

Type medical treatment furnished: Acute Thrombolytic therapy, low Salt diet

Nature of healing process (prognosis): GOOD

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes X no ____

This individual (is)* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual (has)* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: N/A

Current medical profile (by service physician):

P	U	L	H	E	S

Charles M. Masten, MD
(Physician's Signature)

16 JUN 89
(Date Signed)

CHARLES M. MASTEN, MD
LIC#078121
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319; 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY. Failure of member or his physician to provide requested information may result in delay in payment for or application or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 Replaces CAL ARNG Form 40-6-2 17 Feb 88

APPENDIX C (continued)

(Battalion or Squadron Letterhead)

(date)

SUBJECT TRAVEL ORDERS AND AUTHORIZATION FOR TREATMENT

TO MEDICAL TREATMENT FACILITY, ATTN: PATIENT ADMINISTRATION
THE ADJUTANT GENERAL, CALIFORNIA NATIONAL GUARD, ATTN: CAMP-SB
UNITED STATES PROPERTY and FISCAL OFFICER for CALIFORNIA, ATTN: CAUS-TR
TRANSPORTATION OFFICER
Individual Concerned

1. The following member of the California Army National Guard is authorized medical care under the provisions of para 6, NGR 40-3 and para 4-2 AR 40-3 and is ordered to report for treatment as indicated:

(Last Name, First Name, MI., SSN, Rank, Unit, Unit Address and ZIP Code)

Attached to: _____
(Name, Address and ZIP Code of Medical Treatment Facility)

Reporting Date _____ Period _____

Purpose: ☐ Treatment ☐ Evaluation ☐ Remedial Surgery ☐ MEB ☐ PEB

Additional instructions: Report to Patient Administration for an appointment in _____ at _____ hours
(allow 15 minutes for processing) (Clinic or Room)
If desired, Transportation Officer will furnish transportation request and meal tickets. Memorandum copy of transportation request and meal tickets will be forwarded to United States Property and Fiscal Officer for California, Camp San Luis Obispo, CA 93403-8660. Travel of dependents and mileage or monetary allowances are not authorized. Reimbursement for actual expenses is authorized. JTR Vol 1, 6005.

FOR ARNG/ARMY USE

AUTH: ☐ 32 USC 318; 37 USC 204(h) For all injuries incurred in line of duty. Also for diseases incurred in line of duty while under orders not specifying 30 days or less.

☐ 32 USC 319: For diseases incurred in line of duty while under orders specifying 30 days or less. Do not use for diseases incurred during inactive duty training.

Accounting classification: FY 89: Tvl, (Off) 2192060 18-1004 P2U21.1000 (211J,219J) _____ /BF0 S04376, (Enl) 2192060 18-1004 P2U41 1100 (211J,219J) _____ /BF0 S04376 (NOTE: Enter UIC in blank for officer or enlisted accounting classification.)

HOR _____
FORMAT 445

2. Background and status at time of injury/disease are as follows:

Type duty being performed: ☐ IDT ☐ AT ☐ FTTD ☐ REP TRNG ☐ OTHER

Inclusive dates of training: _____

Location where disease or injury occurred: _____

Date of occurrence _____. Diagnosis: _____

Line of Duty Status _____ Events leading to incident: _____

3. Request treatment facility complete CAL ARNG Form 40-6-2. If a DA Form 2173 or CAL ARNG Provisional Form 2173 is inclosed, request Section I of that form also be completed. These two forms should be returned to this headquarters along with any civilian medical bills.

FOR THE COMMANDER:

(Signature and signature block of Adjutant)

CAL ARNG Form 40-6-1 **1 Nov 88** **(Replaces CAL ARNG Form 40-6-1 dated 17 Feb 88)**

APPENDIX C (continued)

JEFFERSON, GEORGE C. **TwinCitiesCommunityHospital**

Templeton, California 93465

CHIEF COMPLAINT: Chest pain of one hour's duration.

HISTORY OF PRESENT ILLNESS: George Jefferson is a 48-year-old, Caucasian male who suffered sudden onset of severe substernal chest pain radiating to both arms at about 11:30 on the morning of admission after having returned from National Guard maneuvers. The patient states that he had suffered a previous mild transient left arm pain at about 5:30 in the morning while carrying a heavy briefcase. This resolved spontaneously, and did not recur until the onset of the severe pain. The patient was brought by helicopter from Camp Roberts immediately to Twin Cities Hospital Emergency Room, where an electrocardiogram at 12:34 P.M. demonstrated an acute anterior myocardial infarction. He was treated in the Emergency Room with sublingual and topical nitroglycerin, as well as intravenous lidocaine because of ectopy.

PAST MEDICAL HISTORY: The patient has no prior history of heart disease, hypertension or diabetes mellitus. He denies history of ulcer disease or bleeding diathesis.

Prior Surgeries: Only repair of left medial meniscus in 1974 due to a chronic post-traumatic injury.

MEDICATIONS: The patient takes no specific medications.

ALLERGIES: NONE KNOWN.

SOCIAL HISTORY: The patient lives in Twin City with his wife and daughter. He does not smoke cigarettes or drink alcohol.

FAMILY HISTORY: The patient's family history is unknown.

REVIEW OF SYSTEMS:

Neurological: Negative.

Pulmonary: Negative.

Cardiovascular: The patient has had light-headedness during the past two weeks.

G.I.: Negative.

G.U.: Negative.

Integumentary: Negative.

(CONTINUED ON PAGE TWO)

Patient Jefferson, George C. Room No. Hospital No. 07-81-21

Physician Charles M. Masten, M.D. Date 19 Jun 89

TCC-155 HISTORY AND PHYSICAL EXAMINATION TC 3025

APPENDIX C (continued)

JEFFERSON, GEORGE C. **TwinCitiesCommunityHospital**

Page 2 **Templeton, California 93465**

PHYSICAL EXAMINATION:

General: The patient is a well-developed and well-nourished, Caucasian male who is alert and oriented but anxious.

Vital Signs: HT: 61". WT: 145 lbs. BP: 134/84 mm.Hg. P: 84 per minute. R: 22 per minute.

HEENT: Head - Normocephalic. Face symmetric. Pupils equal, round and reactive to light and accommodation. Extraocular movements are intact. Funduscopic examination is normal. Ears, nose and throat are normal.

Neck: There is no jugular venous distention. Carotid pulsations are symmetric without bruit. There is no thyromegaly.

Chest: Without deformity or tenderness.

Lungs: Clear to percussion but demonstrate a few inspiratory rales at the left base.

Heart: Cardiac examination demonstrates no displacement of the apical impulse, a normal first heart sound and physiologically split second heart sound with a soft apical atrial gallop. There is no ventricular gallop or murmur.

Abdomen: Soft with normal active bowel sounds and no tenderness or organomegaly.

Rectal: Not performed.

Genitalia: Normal.

Extremities: Symmetric without cyanosis, clubbing or edema. Peripheral pulses are intact and symmetric.

Neurological: Cranial nerves are intact. Deep tendon reflexes are symmetric and normal. Plantar reflexes flexor.

LABORATORY & DIAGNOSTIC DATA: Electrocardiogram demonstrates normal sinus rhythm and an acute anterior and lateral infarct with reciprocal inferior ST-segment depressions.

ASSESSMENT: Acute anterior myocardial infarction.

PLAN: 1) The patient will be admitted to the Coronary Care Unit for tissue plasminogen activator (TPA) thrombolysis.

(CONTINUED ON PAGE THREE)

Patient Jefferson, George C. Room No. Hospital No. 87-81-21

Physician Charles M. Masten, M.D. Date 19 Jun 89

TCC-155 HISTORY AND PHYSICAL EXAMINATION TC 3025

APPENDIX C (continued)

JEFFERSON, GEORGE C. **TwinCitiesCommunityHospital**

Page 3 **Templeton, California 93465**

PLAN (CONT'D):

2) Further diagnostic and therapeutic treatment depends upon the patient's response to acute thrombolytic therapy.

Charles M. Masten, M.D.

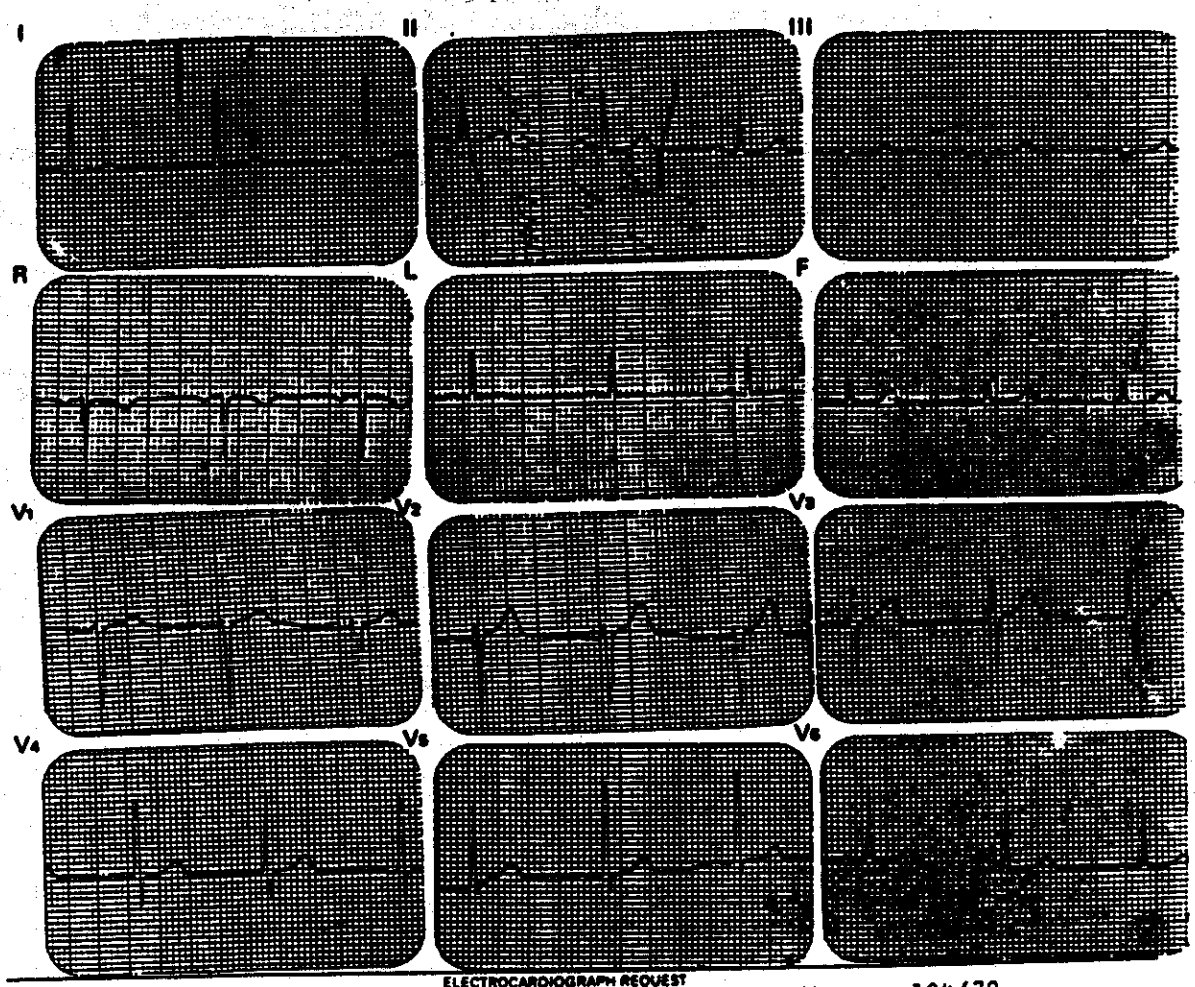
D: 4/10/88-4
T: 4/11/88
gz

Patient Jefferson, George C. Room No. Hospital No. 07-81-21

Physician Charles M. Masten, M.D. Date 19 Jun 89

TCC-188 HISTORY AND PHYSICAL EXAMINATION TC 3025

APPENDIX C (continued)



ELECTROCARDIOGRAPH REQUEST

PREV ECG YES ☐ NO ☐ AMB ☐ BED ☐ EMERG ☐ DIG ☐ QUIN ☐ AGE 48 SEX M B P 104/70 DATE

CLIN DIAG

ORDERED BY Masten M D

ELECTROCARDIOGRAPH REPORT

RHYTHM SINUS ☑ OTHER

RATES ATR 65 VENTR 65 | INTERVALS P R .16 QRS .06 QTc .36 | AXIS .30

DESCRIPTION LIMB LEADS PRECORDIAL LEADS

P

QRS

S T

T U Borderline

PATIENT IDENTIFICATION

-00-14308-Y

Jefferson, George

INTERPRETATION Sinus Arrhythmia.
Within normal limits

DATE 6/16/89 INTERPRETED BY [signature] M D

12-01 PRINTED IN U S A 60

C-8.5

APPENDIX C (continued)

STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
P.O. Box 214405 - 2829 Watt Avenue
Sacramento, California 95821-4405

PERMANENT ORDERS 1-21 5 January 1989

HHC, 40th Inf Div (M)
Co A 340th Spt Bn
Co B (-) 340th Spt Bn
Det 1 Co B 340th Spt Bn
Co C 340th Spt Bn
HHB 40th Inf Div Arty
Btry F 144th FA
HHB 1st Bn 143d FA
Btry A 1st Bn 143d FA
Btry B 1st Bn 143d FA
Btry C 1st Bn 143d FA
Svc Btry 1st Bn 143d FA
HHB 1st Bn 144th FA
Btry A 1st Bn 144th FA
Btry B 1st Bn 144th FA
Btry C 1st Bn 144th FA
Svc Btry 1st Bn 144th FA

The Army National Guard unit shown and its members are ordered to annual training for the period indicated and will proceed from home station to duty station shown. Upon completion of annual training, return to home station and terminate annual training status.

Authority: NGB Training Authority CA-21 FY 89, 32 USC 503 and Sections 142 and 368 California Military and Veterans Code
Duty station: Camp Roberts CA
Period: 10-24 Jun 89 (15 days including travel time) TDC: 101
Accounting classification: Off Pay & alw 2192060 18-1004 P1A10.1000-1100, 1200 S04376; Off Tvl & PD 2192060 18-1004 P1A50.1000-2100 S04376; EM Pay & alw 2192060 18-1004 P1A30.1100-1100.1200 S04376; EM Tvl & PD 2192060 18-1004 P1A60.1100-2100 S04376
Additional instructions: Payrolls will be accomplished in accordance with instructions contained in CAL ARNGR 350-5. Units are authorized group travel by commercial charter bus if appropriate. Accbunting classification: Officer travel: 2192060 18-1004 P1A50.1000 216C S04376. EM travel: 2192060 18-1004 P1A60.1100 216C S04376. Units are authorized group travel by commercial air if appropriate. Accounting classification: Officer travel: 2192060 18-1004 P1A50.1000 217C S04376; EM travel: 2192060 18-1004 P1A60.1100 217C S04376.

BY ORDER OF THE GOVERNOR:

DISTRIBUTION:
D

ANDREW G. WOLF, JR.
COL, (CA) FA, CAL ARNG
Chief of Administration

APPENDIX D

INCAPACITATION PAYROLL TRANSMITTAL

HHB, 2d Bn 144th FA (unit) 8 May 1989 (date)

MEMORANDUM FOR Office of the Adjutant General, ATTN: CAMP-SB, P.O.Box 214405, Sacramento, CA 95821-0405

SUBJECT: Request for Approval of Incapacitation Pay

1. Request incapacitation pay for PFC John J. Doe

SSN 001-22-0345 be approved from 7 May 1989 to 20 May 1989

based on an injury/disease incurred on 23 April 1989

2. Soldier attended training since disability occurred on the following dates: NONE

3. Soldier's MOS/SSI and title when disabled. 13F10 Fire Support Specialist

4. Enlisted soldier's ETS date: 3 Oct 1993 .

5. Civilian employer (indicate if unemployed): Long Beach Naval Shipyards, Long Beach, CA Occupation: Pipefitter

6. Date returned or expected to return to duty:

Military 21 May 1989 Civilian 21 May 1989

7. Address to which check is to be mailed: PFC John J. Doe

1289 Sheild Drive, Norwalk, CA 92050

8. I certify that, during the period indicated in 1 above, the incapacitation of this soldier prevented him/her from performing the duties of his/her MOS/SSI . Verification of civilian income earned and/or lost is attached.

Encl check list
CAL NG Form 37-2H
CAL NG Form 37-2E/2F
CAL ARNG Form 40-6-2
check stub
DA Form 2173/CAL ARNG Form 2173
CAL NG Form 37-D
orders/training schedule

x Curtis M Kelley
(unit commander)
CURTIS M. KELLEY
CPT, FA, CA ARNG
Commanding

CAL NG Form 37-2C

APPENDIX D (continued)

ADAPS PAYROLL CERTIFICATE

NAME: John J. Doe RANK: PFC/E3 UNIT: HHB, 2/144th FA

TL NUMBER: N/A ACN: N/A DATE RECEIVED: N/A

SSN	PRN	ORDERS NUMBER	ORDERS DATE (Y Y M M D D)
001220345	-N/A-	---N/A-	----N/A--

	START DATE (Y Y M M D D)	END DATE (Y Y M M D D)	STATE TAX	ENL BAS	ENLISTED BAS DYS	SBAQ	TVL DAYS
1	890507	890520					
2							
3							
4							

SFD	MILEAGE	VHA		SGLI	OPT	MODE	TDC	SUB

ADDRESS LINE 1 (NUMBER & STREET)
1289 Sheild Drive

ADDRESS LINE 2 (APARTMENT, SUITE, C/O ETC)

ADDRESS LINE 3 (CITY) Norwalk STATE CA ZIP CODE 92050

LEAVE (COMPLETE IF REQUESTING PAYMENT OF ACCRUED LEAVE):

1. _____ DAYS EARNED (_____ TO _____) LESS _____ DAYS TAKEN = ACCRUED LEAVE _____ DAYS
2. DAYS ACCRUED LEAVE PAID SINCE 10 FEB 76 _____ (60 DAYS MAXIMUM)

MISCELLANEOUS ENTITLEMENTS: _____

SUPPLEMENTAL (USE TO CORRECT/CHANGE PAY RECEIVED). STATE PROBLEM, BE CONCISE:

CERTIFICATION OF PERFORMANCE (CHECK ONE):

☐ 1. I certify that I have personal knowledge or I have personally verified the duty requested above has been performed. If the date(s) of performance are different than originally requested, I have entered the correct day(s) of duty and have requested amendment of order.

☐ 2. The individual indicated above has or will report for duty in accordance with competent orders and, upon completion of the duty, is due pay and allowances in the grade and status shown. Any change affecting pay that accrues from this date to the ending date of the duty will be immediately reported to the USPFO. Checks for this duty will be delivered to the individual not earlier that the last day of duty by an agent who has knowledge of or has verified performance of the duty.

8 May 89 — DATE OF CERTIFICATION

x CURTIS M. KELLY — PRINT OR TYPE NAME/SIGNATURE

CHECK: X COMMANDING OFFICER ☐ SENIOR SOLDIER PRESENT

CAL ARNG Form 37-9 REV 1 May 87 Previous Editions will be used until exhausted

Original - USPFO
Copy - Unit

APPENDIX D (continued)

SOLDIERS CLAIM FORM Reference CAL ARNG Pam 40-2	NAME: PFC John L. DOE	SSN: 001-22-0345

INSTRUCTIONS: All incapacitated soldiers are required to prepare this form monthly. It must be included with each incapacitation payroll submitted for payment. Complete the section that pertains to your case: Section 1. - Employed Section 2. - Unemployed Section 3. - Self-Employed Section 4. - All

SECTION 1. - EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/~~disease~~: sprain right wrist in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ 800.00 of civilian income during the period 7 May 1989 to 20 May 1989 (period may only be one calendar month or less for each statment).

3. My claim is substantiated by the enclosed letter(s) from my employer(s).

4. In addition, I certify that I received $ -NONE- from an income protectin plan (including sick leave, etc.). NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 2. - UNEMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that I am unemployed at present, without income from any source, including, but not limited to, unemployment compensation, social security, workman's compensation or Veteran's Administration payments. If I become employed, while receiving incapacitation pay, I understand it will be my responsibility to notify my unit and/or commander to ensure military pay and allowances will be reduced by the income being received at that time.

SECTION 3. - SELF-EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment). I received $ _____ in gross income from being self-employed for the period above.

3. I am self-employed and in order to substantiate my claims of lost civilian income for the period cited in paragraph 2 above, I have enclosed a copy of my latest IRS Form 1040 with supporting documents including schedule c.

4. In addition I certify that I received $ _____ from an income protection plan (including sick leave, etc.) NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 4. - ALL CLAIMANTS

1. I further certify that the information which I have provided regarding this claim is correct. I understand that the penalty for knowingly and willfully making a false claim or a false statement in connection with a claim is a fine of up to $10,000 or imprisonment for up to 5 years or both. (18 USC 287, 1001)

2. I hereby waive my VA compensation. DA Form 3053 and VA Form 21-8951 are enclosed.

3. Privacy Act statement is enclosed.

DATE	SOLDIER'S SIGNATURE
8 May 1989	John L Doe

CAL NG Form 37-2H

APPENDIX D (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below:

(to be completed by unit prior to submission to physician)

Normal military duties for: 13F10 Fire Support Specialist
(Service member's MOS)

Consist of the following: Be able to walk, run, squat, crawl and fire a weapon.

Be totally able to work with no restrictions in a field environment.

I have examined PFC John J. Doe, 001-22-0345 (Name and SSN) on 23 April 1989 (Date)

Disabled from 23 April 1989 (Date) to 20 MAY 1989 (Date).

Date expected to return to normal military duty (without limitation): 21 May 1989

Cause of disability: Right Wrist Sprain (Final Diagnosis)

Type medical treatment furnished: Splint, anti-inflammatory medication, limited duty, ice & elevate in evenings

Nature of healing process (prognosis): Good - Full Recovery expected - Return To Full Duty 4 weeks.

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes X no ____

This individual ~~(is)~~* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual ~~(has)~~* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: N/A

Current medical profile: (by service physician)

P	U	L	H	E	S
1	T3	1	1	1	1

John C. Smith MAJ, MC
(Physician's Signature)

23 April 1989
(Date Signed)

John Q. Smith, MAJ, MC
LIC # 28460921
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319; 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY: Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 Replaces CAL ARNG Form 40-6-2 17 Feb 88

APPENDIX D (continued)

EMPLOYER STATEMENT

INCAPACITATION PERIOD: From 7 May 1989 To 20 May 1989

EMPLOYEE

I, John L. Doe (Typed Name), 001-22-0345 (SSN) hereby authorize the release of the information requested below.

John L. Doe — Employee's Signature — 8MAY89 — Date

EMPLOYER CERTIFICATION

1. During the period indicated above the amount of gross compensation (wages, tips, commissions, ect.) this employee earned was $ -0-. The amount lost because of the disability is $ 800.00 (gross).

2. The amount paid, if any, by an income protection plan, sick leave or advance sick leave or vacation program during this period was $ NONE (gross).

3. I understand that this information is being used by the claimant as the basis of a claim against the United States. I further understand that knowingly and willfully assisting a claimant making a false claim or false statement in connection with a claim is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment.

Date signed: 8 May 1989

Paul W. Jones
(Official Signature)

Supervisor, Pipefitter Division
(Title/Position)

Long Beach Naval Shipyards
(Company Name)

Long Beach, CA 90822-5099
(Address)

(City)

(213) 547 - 6149 ext: 8011
(Telephone Number)

REMARKS:

CAL NG FORM 37-2E

APPENDIX D (continued)

EARNINGS AND LEAVE STATEMENT DA FORM 2790, JUL 73 (AR 37-105)

CONTROL NO	COST CODE	EMPLOYEE NAME	SH	CAT CODE	LV CAT	FI EX	SOCIAL SECURITY NO.	PAY PD END MO	DAY	YR
UB1		JOHN L. DOE GR04-1	1	1	6	M03 M03	001-22-0345	04	21	89

EARNINGS								DEDUCTIONS					BOND	
BASE HOURS	OT HOURS	ND HOURS	HOLIDAY HOURS	CD	OTHER HOURS	RATE	RETIREMENT	FICA	FEDERAL TAX	HEALTH BENEFITS	GROUP LIFE	PUR CD	BALANCE
.00		0	.00		50	10.00	00 .00	80098 24.29	56277 64.70	00 .00	.00		.00

BASE PAY	OT PAY	ND PAY	CD	OTHER PAY	GROSS PAY	STATE TAX	CITY TAX	CD	OTHER DED	UNION DED	BOND DED.	NON-TAX PAY	NET PAY
.00	00 .00	.00		323.50	1066590 800.00	96.00	00.00		.00	15.00	.00		600.01

LEAVE

ANNUAL LEAVE					SICK LEAVE					* LEAVE BALANCE AS OF END OF THIS PAY PERIOD					
PRIOR YEAR BALANCE	TAKEN TO DATE	ACCRUAL TO DATE	MAXIMUM CARRY OVER	USE BY END OF YEAR OR FORFEIT	PRIOR YEAR BALANCE	TAKEN TO DATE	ACCRUED TO DATE	CD	OTHER LEAVE TAKEN	ANNUAL	SICK	LWOP FOR YEAR	LWOP SINCE LAST INC.	COMPEN SATORY	MIL LEAVE USED THIS PAY PERIOD
56	120.0	120	240	.0	32	50	80			56	62	40.00		.00	BAL .00

OTHER EARNINGS CODE
1 HOLIDAY
2 LUMP SUM LV
3 LSL AND HOL
4 CASH AWARD
5 OTHER

OTHER DEDUCTIONS CODE
1 QTRS
2 SGLI
3 QTRS & SGLI
4 UTILITIES
5 DEL TAX
6 LSL REPAY
7 FI 86 604
80-89 UNION DUES
9 OTHER

SHIFT CODE
1 1ST OR DAY SHIFT
2 2D SHIFT
3 3D SHIFT
5 SPLIT SHIFT

FRACTION CODE
2 1/4 HOUR
5 1/2 HOUR
7 3/4 HOUR

OTHER LEAVE TAKEN
H - HOLIDAY
C - COURT
O - OTHER

BOND PURCHASE
1 $ 18 75
2 37 50
3 75 00
4 150 00
5 375.00

* Amount preceded by a minus sign indicates leave owed Government

APPENDIX D (continued)

DISABILITY COUNSELING STATEMENT

I, the undersigned have been counseled on this date, in order to be eligible for continuance of pay and allowances while disabled from an injury or disease in the line or duty that:

1) I must promptly report to my unit when in need of medical or hospital care

2) I cannot seek private medical or hospital care without first obtaining authorization from my unit except for emergency medical care (the request will be processed by my unit for final approval to State Headquarters, CAMP-SB, or National Guard Bureau, NGB, IAW NGR 40-3).

3) I must report without failure to any medical appointment scheduled by my unit or by the doctor treating my condition unless prohibited by another physician from traveling. A statement from prohibiting Doctor is required.

4) I must cooperate fully with the medical personnel providing treatment.

5) I must furnish to my unit, upon completion of each of my medical appointments, the results of that appointment and the date of my next appt.

6) After each monthly visit to military Doctor/Civilian Doctor, I must furnish following statement to my unit:

NOTE: If I go to a civilian doctor without first obtaining approval from my unit, and they must then obtain approval from State Headquarters (OTAG), I must pay the medical bill myself.

a. A statement from the doctor (the CAL ARNG Form 40-6-2) stating that he examined me for that month and showing my condition for that month.

b. I must provide a monthly statement of employment from my employer, to include name, address, telephone number, point of contact, dates worked, position held, and hourly, weekly, or monthly rate of pay. Also, I must provide a copy of my payroll check stub. If self-employed, I must provide a statement of earned income to include a copy of my last Tax form filed with the Internal Revenue Service (all forms). Example: Form 1040 and Schedule C Form 1040, Profit or Loss From Business or Profession to include regular (Form 1040) monthly/weekly/daily record and/or other acceptable proof of earned income, and proof of self employment to include a copy of business license (if appropriate).

7) I further understand that failure to fulfill the above requirements may result in stopping my entitlements for pay and allowances for this disability

8) I WILL REPORT ALL INCOME TO MY UNIT IF I REQUEST INCAPACITATION PAY.

9) I further understand the penalty for willfully making false statements is maximum fine of $10,000 or maximum imprisonment of 5 years or both. (U.S. Code, Title 18, Section 287)

Date 8 May 1989 Signature John L Doe

Name of Counselor/Witness SSG Mary V. Greenwood

DISTRIBUTION:
Original - Unit
Copy - Individual Concerned
Copy - OTAG (CAMP-SB)

CAL NG FORM 37-D

APPENDIX D (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-2; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code) (818)447-1144
CHANNELS	OTAG (CAMP-SB) P.O. Box 214405 Sacramento, CA 95821-0405	HHB 2d Bn 144th FA 260th W. Huntington Drive Arcadia, CA 91006-3401

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
DOE, John J.	001-22-0345	PFC

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
HHB, 2d Bn 144th FA Arcadia, CA	23 Apr 89	Camp Roberts, CA

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☒ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL

7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☒ MILITARY: Silas B. Hayes ACH, Ft. Ord, CA

8. HOUR AND DATE ADMITTED: N/A

9. HOUR AND DATE EXAMINED: 1530 23 Apr 89

10. DIAGNOSIS AND EXTENT OF ☒ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain): Sprained Right Wrist

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☒ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):
b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).
c. INJURY OR DISEASE ☒ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.
d. INJURY OR DISEASE ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).
e. CONDITION ☐ DID ☒ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☒ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT: ☐ NONE ESTIMATE OF TIME LOSS (Days): ☒ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL

13. BLOOD ALCOHOL TEST MADE ☐ YES ☐ NO

14. NO. OF MG ALCOHOL/100 ML BLOOD: N/A

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (How, where, when): Around 1445 hours, 23 Apr 89, PFC Doe was assisting in field artillery hasty displacement at firing point 20. He fell while loading M577 and sprained his right wrist.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE
23 Apr 89	John Q. Smith, MAJ, MD	John Q. Smith, MAJ, MD

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS: ☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE

20. HOUR AND DATE OF ABSENCE: a. FROM: N/A b. TO: N/A

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) ☐ YES ☐ NO

22. INDIVIDUAL WAS ON ☐ ACTIVE DUTY ☒ ACTIVE DUTY FOR TRAINING ☐ INACTIVE DUTY TRAINING

23. HOUR AND DATE OF TRAINING: a. BEGAN: 0600 22 Apr 89 b. END: 1700 6 May 89

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL
N/A	N/A	N/A	N/A

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).

PFC Doe was loading a M577 Command Carrier for hasty displacement from firing point 20 Camp Roberts, CA. During the loading, PFC Doe slipped and fell from the top of the M577, landing on his right side and wrist. SM was evacuated to the Camp Roberts TMC, where it was determined that his right wrist was sprained. IN LINE OF DUTY. SSG Paul W. Spencer, 987-65-4321, witnessed this accident. Address unknown.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☒ NO

32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☒ YES ☐ NO

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE
23 April 1989	CURTIS M. KELLEY, CPT, FA, CDR	Curtis M. Kelley, CPT

CAL ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX D (continued)

CAMP-SB: John J. DOE, PFC
SSN: 001-22-0345

State of California, Military Dept.
OTAG, Sacramento, CA 95821 DATE: 3 May 89

APPROVED: (The reviewing authority and the approving authority are the same)

BY AUTHORITY OF THE SECRETARY OF THE ARMY

DENNIS E. BANOWETZ
MAJ, INF, CAL ARNG
Chief, Support Branch

APPENDIX D (continued)

STATE OF CALIFORNIA
OFFICE OF THE ADJUTANT GENERAL
P.O. Box 214405 - 2829 Watt Avenue
Sacramento, California 95821-4405

PERMANENT ORDERS 62-13 4 November 1988

HHC 1st Bde 40th Inf Div
HHC 2d Bn 160th Inf
Det 1 HHC 2d Bn 160th Inf
Co A 2d Bn 160th Inf
Co B 2d Bn 160th Inf
Co C 2d Bn 160th Inf
Co D 2d Bn 160th Inf
Det 1 Co D 2d Bn 160th Inf
Co E 2d Bn 160th Inf
HHC 3d Bn 160th Inf
Co A 3d Bn 160th Inf
Co B 3d Bn 160th Inf
Co C 3d Bn 160th Inf
Co D 3d Bn 160th Inf
Co E 3d Bn 160th Inf
HHC 1st Bn 185th Armor
Co A 1st Bn 185th Armor
Co B 1st Bn 185th Armor
Co C 1st Bn 185th Armor
Co D 1st Bn 185th Armor
HHB 2d Bn 144th FA
Btry A 2d Bn 144th FA
Btry B 2d Bn 144th FA
Btry C 2d Bn 144th FA
Svc Btry 2d Bn 144th FA
HHD 40th Spt Bn
Co A 40th Spt Bn
Co B 40th Spt Bn
Co C 40th Spt Bn
Det 2 Co A 132d Engr Bn
40th Pers Svc Co

The Army National Guard unit shown and its members are ordered to annual training for the period indicated and will proceed from home station to duty station shown. Upon completion of annual training, return to home station and terminate annual training status.

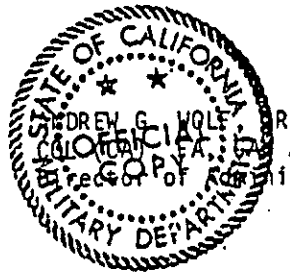
Authority: NGB Training Authority CA-11 FY 89, 32 USC 503 and Sections 142 and 368 California Military and Veterans Code
Duty station: Camp Roberts CA
Period: 22 Apr - 6 May 89 (15 days including travel time) TDC: 101
Accounting classification: Off Pay & alw 2192060 18-1004 P1A10.1000-1100,1200 S04376
Off Tvl & PD 2192060 18-1004 P1A50.1000-2100 S04376
EM Pay & alw 2192060 18-1004 P1A30.1100-1100,1200 S04376
EM Tvl & PD 2192060 18-1004 P1A60.1100-2100 S04376
Additional instructions: Payrolls will be accomplished in accordance with instructions contained in CAL ARNGR 350-5. Units are authorized group travel by commercial charter bus if appropriate. Accounting classification:

APPENDIX D (continued)

Permanent Orders 62-13 OTAG 4 Nov 88

Officer travel 2192060 18-1004 P1A50.1000 216C S04376. EM travel 2192060 18-1004 P1A60.1100 216C S04376. Units are authorized group travel by commercial air if appropriate. Accounting classification: Officer travel 2192060 18-1004 P1A50.1000 217C S04376; EM travel 2192060 18-1004 P1A60.1100 217C S04376. Duty is considered Field conditions, and reimbursement for per diem will be in accordance with JTR VOL 1 Para M6000(1)(a)(3)(1) Individuals are required to submit Request for Orders (NGB Form 102-10/ DD Form 1610) to CAOT-TO IAW CAL ARNGR 310-4 when travel and per diem are required.
Format: 250

BY ORDER OF THE GOVERNOR:



ANDREW G. WOLF, JR.
COL, CA, ARNG
Director of Administration

DISTRIBUTION:
D

OFFICIAL COPY

APPENDIX E

APPENDIX E (SCIF)

HEADQUARTERS 143D EVACUATION HOSPITAL
California Army National Guard
Armed Forces Reserve Center
Los Alamitos, California 90720

MBEH-A-AJ 15 May 1990

MEMORANDUM FOR The Adjutant General, State Military Department, ATTN: CAMP-SB, Sacramento, CA 95821

SUBJECT: Request for State Compensation

1. Request that your office take action to award temporary State Compensation Insurance Fund benefits (SCIF) to Staff Sergeant Robert Amiga, 545-71-5678, this organization.

2. Staff Sergeant Amiga was injured on 15 May 1990 during a field exercise and has been unable to return to work. Although a line of duty is being processed there have been additional problems with his civilian employer that will delay the incapacitation payroll request. SSG Amiga is in need of immediate financial assistance to pay his bills and support his family.

3. Staff Sergeant Amiga has been counseled that if this request is approved any SCIF financial assistance (temporary disability payments) must be repaid upon receipt of federal incapacitation pay as required by law; he has agreed to do so and a repayment agreement is enclosed.

4. All available documents have been enclosed for your review.

Deborah Snats

DEBORAH M. SNATS
CPT, MC, CA ARNG
Adjutant

Encl
as

CF: Cdr, 175th Med Bde

APPENDIX E (continued)

PLEASE TYPE ALL INFORMATION, IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain last copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** P.O. BOX 807 SAN FRANCISCO, CA 94101-0807 Telephone: (415) 565-1344	OSHA Case or File No.

PICA XXX ELITE XXX ← TYPEWRITER ALIGNMENT GUIDE → PICA XXX ELITE XXX

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. FIRM NAME — DIVISION: STATE OF CALIFORNIA - MILITARY DEPARTMENT
1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP): P.O. BOX 214405, Sacramento, CA 95821
2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP)
3A. LOCATION CODE
4A. NATURE OF BUSINESS e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.: MILITARY
5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
4B. TYPE OF EMPLOYER: PRIVATE | STATE: X | CITY | COUNTY | SCHOOL DISTRICT | OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME: AMIGA, ROBERT
7. DATE OF BIRTH (MM-DD-YY)
8. HOME ADDRESS (Number and Street, City, ZIP): 6312 Commodore Drive, Los Alamitos, CA 90720
8A. PHONE NUMBER
9. SEX: Male: X | Female
10. OCCUPATION (Regular job title, not specific activity at time of injury): Medic (Military)
11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED: State Military Department
12A. DATE OF HIRE (MM-DD-YY)
13. HOURS USUALLY WORKED: HOURS PER DAY: 8
13A. DAYS PER WEEK
13B. TOTAL WEEKLY HOURS
13C. Under what class code of your policy were wages assigned?
14. GROSS WAGES/SALARY: 1750 PER: HOUR | DAY | WEEK | TWO WEEKS | MONTH | OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City): Camp San Luis Obispo, CA
15A. COUNTY
15B. ON EMPLOYER'S PREMISES? YES: X | NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.): Loading a truck with Field Equipment
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.): Sergeant Amiga was lifting a 50 lb box of equipment and injured his back.
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.:
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc.: back strain
19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.: lower back
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
22. DATE OF INJURY OR ILLNESS (MM-DD-YY): 05 15 90
23. TIME OF DAY: 930 a.m.: X | p.m.
24. Did employee lose at least one full day's work after the injury? NO | YES: X — Date Last Worked (MM-DD-YY): 05 15 90
25. HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY): No, still off work: X | Yes, date returned:
26. DID EMPLOYEE DIE? NO: X | YES — Date of Death (MM-DD-YY):
27. WAS ANOTHER PERSON RESPONSIBLE? NO: X | YES
28. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? NO: X | YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 (REV. 6-88)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.

FORM 5020 (REV. 5) April 1987

APPENDIX E (continued)

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS	TIME OF DAY
Robert Amiga	15/ 05 /90	0930 ☒ A.M. ☐ P.M.

HOME ADDRESS (Number, Street, City, Zip Code)
6312 Commodore Drive, Los Alamitos, CA 90720

WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)
Camp San Luis Obispo, CA 93403

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

Our unit was involved in a field exercise at CSLO. We wre loading equipment on a truck when I felt a sharp pain in my back. I was unable to continue to work and reported this injury to the first sergeant.

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost. You also may consult an attorney.

I gave this form to my employer on (date) 15 May, 19 90.

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT " until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury	Date claim form was provided to employee	Date claim form was received
05/15/90	05/15/90	05/15/90

Name of Employer
CAL NATIONAL GUARD, HQ 143d EMAC Hospital

Signature of Employer/Representative
Robert Suits

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1-90)

STATE FUND COPY

APPENDIX F

REPORT OF INVESTIGATION
LINE OF DUTY AND MISCONDUCT STATUS
(AR 600–33 or AFR 35-67)

DATE

1 INVESTIGATION OF ☐ INJURY ☐ DISEASE ☐ DEATH

2 TO: *(Major Army or Air Force Commander)*

3 STATUS
a. ☐ REGULAR OR EAD
b. CALLED OR ORDERED TO AD FOR (1) ☐ MORE THAN 30 DAYS (2) ☐ 30 DAYS OR LESS
c. ☐ INACTIVE DUTY TRAINING *(Type)*
d. ☐ SHORT TOUR OF ACTIVE DUTY FOR TRAINING

4 LAST NAME FIRST NAME MIDDLE INITIAL | 5. SERVICE NO./SSAN | 6 GRADE

7 ORGANIZATION AND STATION OF INDIVIDUAL

8 OTHER MILITARY PERSONNEL INVOLVED IN THE SAME INCIDENT *(Last Name - First Name - Middle Initial)*	SERVICE NUMBER OR SSAN	GRADE	LOD INVESTIGATION MADE YES	LOD INVESTIGATION MADE NO

DURATION *(Applies ONLY to 1c and 3d)*

	DATE	HOUR
START		
FINISH		

9 BASIS FOR FINDINGS *(As determined by investigation)*

a CIRCUMSTANCES | (1) HOUR | (2) DATE | (3) PLACE

(4) HOW SUSTAINED | b. MEDICAL DIAGNOSIS

c ☐ WAS ☐ WAS NOT PRESENT FOR DUTY

d ABSENT ☐ WITH ☐ WITHOUT AUTHORITY

(Do not complete e and f in death cases)
e. INTENTIONAL MISCONDUCT OR NEGLECT ☐ WAS ☐ WAS NOT THE PROXIMATE CAUSE
f. ☐ WAS ☐ WAS NOT MENTALLY SOUND

g REMARKS

10 FINDINGS *(Do not complete in death cases)*
☐ IN LINE OF DUTY
☐ NOT IN LINE OF DUTY NOT DUE TO OWN MISCONDUCT
☐ NOT IN LINE OF DUTY DUE TO OWN MISCONDUCT

ORGANIZATION AND STATION OF INVESTIGATING OFFICER

SIGNATURE AND TYPED NAME OF INVESTIGATING OFFICER

GRADE | BRANCH | SERVICE NO./SSAN

ACTION BY APPOINTING AUTHORITY

HEADQUARTERS | DATE

☐ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME

GRADE | BRANCH | SERVICE NO./SSAN

ACTION BY REVIEWING AUTHORITY

HEADQUARTERS | DATE

☐ APPROVED ☐ DISAPPROVED
(Reasons and substituted findings are on reverse)

SIGNATURE AND TYPED NAME

GRADE | BRANCH | SERVICE NO./SSAN

FOR ACTION OF OFFICE INDICATED IN ITEM 2

DD FORM 1 OCT 68 261

REPLACES EDITION OF 1 AUG 68 EXISTING SUPPLIES OF WHICH WILL BE USED UNTIL EXHAUSTED

APPENDIX F (continued)

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see NGR 600-3; the proponent agency is The State Military Department

THRU: (Include ZIP Code)	TO: (Include ZIP Code)	FROM: (Include ZIP Code)

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☐ OUT PATIENT ☐ ADMITTED ☐ DEAD ON ARRIVAL	7. NAME OF HOSPITAL OR TREATMENT FACILITY ☐ CIVILIAN ☐ MILITARY

8. HOUR AND DATE ADMITTED	9. HOUR AND DATE EXAMINED

10. DIAGNOSIS AND EXTENT OF ☐ INJURY ☐ DISEASE ☐ RESULTING IN DEATH (Explain)

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☐ WAS NOT UNDER THE INFLUENCE OF ☐ ALCOHOL ☐ DRUGS (Specify):

b. INDIVIDUAL ☐ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate).

c. INJURY OR DISEASE ☐ IS ☐ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE.

d. INJURY OR DISEASE ☐ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY (Add basis for opinion in item 15).

e. CONDITION ☐ DID ☐ DID NOT EXIST PRIOR TO SERVICE AND ☐ WAS ☐ WAS NOT AGGRAVATED BY SERVICE.

12. THE FOLLOWING DISABILITY MAY RESULT ☐ NONE ESTIMATE OF TIME LOSS (Days): ☐ TEMPORARY ☐ PERMANENT PARTIAL ☐ PERMANENT TOTAL	13. BLOOD ALCOHOL TEST MADE ☐ YES ☐ NO	14. NO. OF MG ALCOHOL/100 ML BLOOD

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (how, where, when)

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIGNATURE

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATUS ☐ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY ☐ ABSENT WITH AUTHORITY: ☐ ON PASS ☐ ON LEAVE	20. HOUR AND DATE OF ABSENCE	
	a. FROM	b. TO

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance) ☐ YES ☐ NO

22. INDIVIDUAL WAS ON ☐ ACTIVE DUTY ☐ ACTIVE DUTY FOR TRAINING ☐ INACTIVE DUTY TRAINING	23. HOUR AND DATE OF TRAINING	
	a. BEGAN	b. END

24. MEMBER WAS INJURED OR DIED OF INJURIES OR DISEASE PROCEEDING ☐ IN A DIRECT ROUTE ☐ IN AN INDIRECT ROUTE ☐ TO DUTY ☐ FROM DUTY.

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL

29. ADDITIONAL INSTRUCTIONS FOR INJURIES OR DEATHS CAUSED BY INJURIES RECEIVED IN ROUTE TO OR FROM TRAINING: INCLUDE MANNER OF TRAVEL, ROUTE FOLLOWED AND POINT OF INCIDENT IN ITEM 30. IF PROCEEDING FROM DUTY, INCLUDE RELEASE TIME AND DESTINATION ALSO.

30. FINDINGS BASED ON COMMANDER'S INVESTIGATION (Include names, SSNs and addresses of witnesses - continue on reverse if needed).

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☐ YES ☐ NO	32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☐ YES ☐ NO	

33. DATE	34. TYPE NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISER	35. SIGNATURE

CAL. ARNG Form 2173 1 JUN 88 TO BE USED IN PLACE OF DA FORM 2173 BY THE CALIFORNIA ARMY NATIONAL GUARD

APPENDIX F (continued)

_____
(Battalion or Squadron Letterhead)

_____
(date)

SUBJECT: TRAVEL ORDERS AND AUTHORIZATION FOR TREATMENT

TO: MEDICAL TREATMENT FACILITY, ATTN: PATIENT ADMINISTRATION
THE ADJUTANT GENERAL, CALIFORNIA NATIONAL GUARD, ATTN: CAMP-SB
UNITED STATES PROPERTY and FISCAL OFFICER for CALIFORNIA, ATTN: CAUS-TR
TRANSPORTATION OFFICER
Individual Concerned

1. The following member of the California Army National Guard is authorized medical care under the provisions of para 6, NGR 40-3, and para 4-2, AR 40-3 and is ordered to report for treatment as indicated:

_____
(Last Name, First Name, MI., SSN, Rank, Unit, Unit Address and ZIP Code)

Attached to: _____
(Name, Address and ZIP Code of Medical Treatment Facility)

Reporting Date: _____ Period: _____

Purpose: ☐ Treatment ☐ Evaluation ☐ Remedial Surgery ☐ MEB ☐ PEB

Additional instructions: Report to Patient Administration for an appointment in _____ at _____ hours
(Clinic or Room)
(allow 15 minutes for processing).
If desired, Transportation Officer will furnish transportation request and meal tickets. Memorandum copy of transportation request and meal tickets will be forwarded to United States Property and Fiscal Officer for California, Camp San Luis Obispo, CA 93403-8660. Travel of dependents and mileage or monetary allowances are not authorized. Reimbursement for actual expenses is authorized. JTR Vol 1, 6005.

FOR ARNG/ARMY USE

AUTH: ☐ 32 USC 318; 37 USC 204(h) For all injuries incurred in line of duty. Also for diseases incurred in line of duty while under orders not specifying 30 days or less.

☐ 32 USC 319: For diseases incurred in line of duty while under orders specifying 30 days or less. Do not use for diseases incurred during inactive duty training.

Accounting classification: FY 89: Tvl, (Off) 2192060 18-1004 P2U21.1000 (211J,219J) _____ /BF0 S04376; (Enl) 2192060 18-1004 P2U41 1100 (211J,219J) _____ /BF0 S04376. (NOTE: Enter UIC in blank for officer or enlisted accounting classification.)

HOR _____
FORMAT 445

2. Background and status at time of injury/disease are as follows:

Type duty being performed: ☐ IDT ☐ AT ☐ FTTD ☐ REP TRNG ☐ OTHER

Inclusive dates of training: _____

Location where disease or injury occurred: _____

Date of occurrence: _____ Diagnosis: _____

Line of Duty Status: _____ Events leading to incident: _____

_____

3. Request treatment facility complete CAL ARNG Form 40-6-2. If a DA Form 2173 or CAL ARNG Provisional Form 2173 is inclosed, request Section I of that form also be completed. These two forms should be returned to this headquarters along with any civilian medical bills.

FOR THE COMMANDER:

(Signature and signature block of Adjutant)

CAL ARNG Form 40-6-1 **1 Nov 88** **(Replaces CAL ARNG Form 40-6-1 dated 17 Feb 88)**

APPENDIX F (continued)

DISABILITY STATEMENT AND COMPLETE REPORT OF ATTENDING PHYSICIAN

Note to attending physician: Please complete the statement below if this Guard member is incapacitated and cannot perform normal military duties. To help you make that determination, the individual's normal military duties are outlined below:

(to be completed by unit prior to submission to physician)

Normal military duties for: _____
(Service member's MOS)

Consist of the following _____

_____

I have examined _____ on _____
(Name and SSN) (Date)

Disabled from _____ to _____.
(Date) (Date)

Date expected to return to normal military duty: _____
(without limitation)

Cause of disability: _____
(Final Diagnosis)

Type medical treatment furnished: _____

_____

Nature of healing process (prognosis): _____

_____

Is it in the best interest of the Federal Government to continue medical treatment rather than to place the service member before a Medical Evaluation Board? yes ____ no ____

This individual (is)* (is not)* permanently disabled. If permanently disabled or if temporarily disabled for more than 90 days, the individual (has)* (has not)* been scheduled for a (Medical Evaluation Board)* (Physical Evaluation Board)* in accordance with AR 40-3.

Board date: _____

Current medical profile: (by service physician)

P	U	L	H	E	S

_____
(Physician's Signature)

_____
(Date Signed)

_____
(Typed or printed name of physician and medical treatment facility)

*Strike out inapplicable term

(THIS FORM IS AFFECTED BY THE PRIVACY ACT OF 1974)

AUTHORITY: 32 USC 318 and 319: 37 USC 204(h); Sections 340 and 341, California Military and Veterans Code.

PRINCIPAL PURPOSES: To verify member's disability caused by service connected injury or disease. To determine final diagnosis. Social Security Number is used for identification.

ROUTINE USES: Used within the California Army National Guard to determine eligibility for disability pay and treatment in a service hospital or at government expense. Used to determine final diagnosis in line of duty investigations and determinations. Used by State Compensation Insurance Fund as an agent of the State of California to verify entitlement to State Compensation when federal benefits are delayed.

DISCLOSURE IS VOLUNTARY: Failure of member or his physician to provide requested information may result in delay in payment for incapacitation or delay in final disposition of member's case (Comp Gen decision #B-185404, 2 Aug 76).

CAL ARNG Form 40-6-2 1 Nov 88 **Replaces CAL ARNG Form 40-6-2 17 Feb 88**

APPENDIX F (continued)

SWORN STATEMENT

For use of this form, see AR 190-45; the proponent agency is Office of The Deputy Chief of Staff for Personnel.

LOCATION	DATE	TIME	FILE NUMBER

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER.	GRADE/STATUS

ORGANIZATION OR ADDRESS

I, _____, WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

EXHIBIT	INITIALS OF PERSON MAKING STATEMENT	PAGE 1 OF _____ PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF___ TAKEN AT___ DATED___ CONTINUED." THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT AND BE INITIALED AS "PAGE___ OF___ PAGES." WHEN ADDITIONAL PAGES ARE UTILIZED, THE BACK OF PAGE 1 WILL BE LINED OUT, AND THE STATEMENT WILL BE CONCLUDED ON THE REVERSE SIDE OF ANOTHER COPY OF THIS FORM.

DA FORM 1 JUL 72 2823 SUPERSEDES DA FORM 2823, 1 JAN 68, WHICH WILL BE USED.

APPENDIX F (continued)

STATEMENT (Continued)

AFFIDAVIT

_____ HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE _____. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

_____
(Signature of Person Making Statement)

WITNESSES:

_____

_____

_____
ORGANIZATION OR ADDRESS

_____

_____

_____
ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this _____ day of _____, 19____

at _____

_____
(Signature of Person Administering Oath)

_____
(Typed Name of Person Administering Oath)

_____
(Authority To Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT _____ PAGE _____ OF _____ PAGES

☆ U.S. GPO:1977-0-765-037/68

APPENDIX F (continued)

DISPOSITION FORM

OFFICE SYMBOL OR FILE REFERENCE	SUBJECT
	Request for Approval of Incapacitation Pay for _____

THRU: OTAG
Support Branch

FROM

DATE

CMT 1

1. Request that incapacitation pay for the above individual be approved for lost civilian time from _____ to _____ and/or lost drill time _____, based on an/a injury/disease incurred in line of duty on
(Drill Dates)
_____ while undergoing _____.
(Date Injury/Disease) (Type of training)

2. The following information and documents are furnished to support this request:

a. A copy of approved LOD.
b. Member is expected to return to normal military duty by _____.
c. A current disability statement/CAL ARNG Form 40-6-2.
d. Employer statement CAL NG Form 37-2E, or self-employment statement CAL NG Form 37-2F.
e. Computation Worksheet CAL NG Form 37-2G. (Section I Only)
f. The member has/has not attended training since his/her disability. If so, the dates and type of training (IDT, ADT, AT, etc.) attended were: _____.
g. Member's MOS/SSI, to include title, at the time of injury or onset of disease: _____. Member's PEBD: _____.
h. Member's current ETS or MRD date: _____.
i. Civilian Occupation: Employed as _____ for _____.
(Position) (Firm)
_____. Has/has not returned to work since _____.
(Firm address) (Date)
j. Member returned to military duty on _____ and/or civilian _____.
(Date) (Date)
occupation.

3. I certify that the injury/disease cited in the attached LOD determination has in fact incapacitated this individual from performing the normal assigned military duties of the MOS/SSI indicated during the period of this payroll. I further certify that proper verification of lost civilian income is attached.

Encls
as

_____
(Sig Block Cmdr)

CAL NG Form 37-2C (15 Jun 87)

APPENDIX F (continued)

ADAPS PAYROLL CERTIFICATE

NAME: _____ RANK: _____ UNIT: _____

TL NUMBER: _____ ACN: _____ DATE RECEIVED: _____

SSN	PRN	ORDERS NUMBER	ORDERS DATE Y Y M M D D

	START DATE Y Y M M D D	END DATE Y Y M M D D	STATE TAX	ENL BAS	ENLISTED BAS DYS	SBAQ	TVL DAYS
1							
2							
3							
4							

SFD	MILEAGE	VHA		SGLI	OPT	MODE	TDC	SUB

ADDRESS LINE 1 (NUMBER & STREET)

ADDRESS LINE 2 (APARTMENT, SUITE, C/O ETC)

ADDRESS LINE 3 (CITY) STATE ZIP CODE

LEAVE (COMPLETE IF REQUESTING PAYMENT OF ACCRUED LEAVE):

1. _____ DAYS EARNED (_____ TO _____) LESS _____ DAYS TAKEN = ACCRUED LEAVE _____ DAYS
2. DAYS ACCRUED LEAVE PAID SINCE 10 FEB 76 _____ (60 DAYS MAXIMUM)

MISCELLANEOUS ENTITLEMENTS: _____

SUPPLEMENTAL (USE TO CORRECT/CHANGE PAY RECEIVED). STATE PROBLEM, BE CONCISE:

_____

CERTIFICATION OF PERFORMANCE (CHECK ONE):

☐ 1 I certify that I have personal knowledge or I have personally verified the duty requested above has been performed If the date(s) of performance are different than originally requested, I have entered the correct day(s) of duty and have requested amendment of order

☐ 2 The individual indicated above has or will report for duty in accordance with competent orders and, upon completion of the duty, is due pay and allowances in the grade and status shown. Any change affecting pay that accrues from this date to the ending date of the duty will be immediately reported to the USPFO Checks for this duty will be delivered to the individual not earlier that the last day of duty by an agent who has knowledge of or has verified performance of the duty

_____ X _____

DATE OF CERTIFICATION PRINT OR TYPE NAME/SIGNATURE

CHECK ☐ COMMANDING OFFICER ☐ SENIOR SOLDIER PRESENT

CAL ARNG Form 37-9 REV 1 May 87

Original - USPFO
Copy - Unit

Previous Editions will be used until exhausted

APPENDIX F (continued)

INSTRUCTIONS

NAME, RANK, UNIT	Self explanatory
TL NUMBER	Your transmittal letter number
SSN	Social Security Number
PRN	Payroll Number, i.e., J01
ORDER NUMBER	11-3 code as 011-03 (send two (2) copies)
ORDER DATE	Year-Month-Day (YYMMDD)
TRI START & END DATES	First and last day of duty (YYMMDD), No break in Duty Days.
TR2, 3, & 4	Use only if there are breaks in duty: i.e., on duty weekdays only.
ADDRESS LINES 1, 2, & 3	Self explanatory.

LEAVE

1. Enter number of days earned, beginning and end dates, leave taken (DA 31), and accrued leave.
2. Enter the number of days of accrued leave paid since 10 Feb 76 (see DD Forms 214, PFR etc.).

NOTE: A. Leave may be paid on a supplemental payroll or on the final voucher. In either case, complete 1 & 2 above and attach one copy of all previous DA 2139's and orders to substantiate duty performed.

B. DA 2139's reflecting accrued leave paid should be filed in the permanent section of the PFR (NGB 37-104-3).

MISCELLANEOUS ENTITLEMENTS

Note any entitlements that are not automatically paid, such as: BAQ w/o dependents, enlisted BAS, Saved-pay, VHA and FSA. Payment of enlisted BAS and/or BAQ W/O must be supported by a statement on non-availability in the orders or a DD Form 1351-5 from the duty station. Permission to mess separately may be granted by the unit commander on a DD Form 2496.

SUPPLEMENTALS

1. Supplemental payrolls are used to correct erroneous pay caused by incorrect information received or input by ADAPS. DO NOT use the term "Supplemental" to pay additional duty days as this may delay payment.

2. Send one (1) copy of all supporting documents with your request for supplemental pay. Supporting documents include: all orders, DA Forms 2139 & 3298, federal recognition, etc.

3. Correct payment for BAQ with dependents, promotions, incentive pay and time-in-service depends on information in the SIDPERS data base. It is the unit's responsiblility to telephone SIDPERS to insure that the data base has been corrected before sending the supplemental to ADAPS.

CERTIFICATE OF PERFORMANCE

1. If duty has been performed, check block #1.

2. If duty has started but is not complete, check block #2.

3. An A agent is required if duty has not started. Coordinate with ADAPS.

APPENDIX F (continued)

EMPLOYEE AND EMPLOYER CERTIFICATION

Incapacitation Period _____ To _____

EMPLOYEE

I, _____ _____ hereby authorize the release of
(Typed Name) (SSN)
information requested below, under provision of Title 5, U.S. Code Section 552. This information is required to determine entitlement to Incapacitation Pay from the Federal Government as a result of an injury/disease condition incurred while performing military duty with the Army National Guard. I certify that I received no income from any source, including credit disability insurance, during the incapacitation period above except as follows:

_____

_____.
(If none, so indicate)

x_____ _____
Employee's Signature Date

EMPLOYER

I certify that the above employee has been/was employed by this firm/company from _____ to _____. The last/present position held was _____.

1. Description of duties performed: _____
_____.

2. Did the injury/disease prevent performance of all duties? _____

3. The average gross wages earned immediately before injury/disease was $_____ per _____.

Please attach copies of payroll documents (check stubs, etc.).

a. If seasonal worker, the usual months of employment are _____ to _____.

b. Average number of hours worked per week _____.

c. If paid for overtime, what is the rate and average number of hours worked per week? $_____ _____

d. If other than Monday thru Friday, which days are worked? _____ _____.

CAL ARNG Form 37-2E (1 April 1989) Previous Editions are Obsolete

APPENDIX F (continued)

4. If the employee worked during the incapacitation period shown above, please explain _____.

5. If the employee used sick leave or vacation during any part of the incapacitation period or money was provided by a company income protection plan, what were the dates? _____ What was the amount paid ? $_____

6. Please make any comments or give any information you feel will help in the determination of Incapacitation Pay. _____

_____

_____

_____

Date signed: _____ x_____
(Signature)

_____
(Title/Position)

_____
(Company Name)

_____
(Address)

_____
(Address)

_____
(Area Code - Phone Number)

APPENDIX F (continued)

INCAPACITATION PAYROLL TRANSMITTAL

_____(unit) _____(date)

MEMORANDUM FOR Office of the Adjutant General, ATTN: CAMP-SB, P.O.Box 214405, Sacramento, CA 95821-0405

SUBJECT: Request for Approval of Incapacitation Pay

1. Request incapacitation pay for _____

SSN_____ be approved from _____ to _____

based on an injury/disease incurred on _____

2. Soldier attended training since disability occurred on the following dates: _____

3. Soldier's MOS/SSI and title when disabled._____

_____

4. Enlisted soldier's ETS date: _____ .

5. Civilian employer (indicate if unemployed):_____

_____Occupation:_____

6. Date returned or expected to return to duty:

Military_____Civilian_____

7. Address to which check is to be mailed:_____

_____

8. I certify that, during the period indicated in 1 above, the incapacitation of this soldier prevented him/her from performing the duties of his/her MOS/SSI . Verification of civilian income earned and/or lost is attached.

X_____
(unit commander)
_____

Encl check list
CAL NG Form 37-2H
CAL NG Form 37-2E/2F
CAL ARNG Form 40-6-2
check stub
DA Form 2173/CAL ARNG Form 2173
CAL NG Form 37-D
orders/training schedule

CAL NG Form 37-2C (1 Jan 90)

APPENDIX F (continued)

SOLDIERS CLAIM FORM Reference CAL ARNG Pam 40-2	NAME:	SSN:

INSTRUCTIONS: All incapacitated soldiers are required to prepare this form monthly. It must be included with each incapacitation payroll submitted for payment. Complete the section that pertains to your case: Section 1. - Employed Section 2. - Unemployed Section 3. - Self-Employed Section 4. - All

SECTION 1. - EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment).

3. My claim is substantiated by the enclosed letter(s) from my employer(s).

4. In addition, I certify that I received $ _____ from an income protectin plan (including sick leave, etc.). NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 2. - UNEMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that I am unemployed at present, without income from any source, including, but not limited to, unemployment compensation, social security, workman's compensation or Veteran's Administration payments. If I become employed, while receiving incapacitation pay, I understand it will be my responsibility to notify my unit and/or commander to ensure military pay and allowances will be reduced by the income being received at that time.

SECTION 3. - SELF-EMPLOYED SOLDIER

1. I herby certify that I incurred/aggravated the following injury/disease: _____ in the line of duty while participating in military training/traveling directly to/from military training.

2. I further certify that as a result of the above described injury/disease, I suffered a loss of $ _____ of civilian income during the period _____ to _____ (period may only be one calendar month or less for each statment). I received $ _____ in gross income from being self-employed for the period above.

3. I am self-employed and in order to substantiate my claims of lost civilian income for the period cited in paragraph 2 above, I have enclosed a copy of my latest IRS Form 1040 with supporting documents including schedule c.

4. In addition I certify that I received $ _____ from an income protection plan (including sick leave, etc.) NOTE: If the soldier does not have sick leave, vacation pay, or any other income protection insurance pay, he/she must so state.

SECTION 4. - ALL CLAIMANTS

1. I further certify that the information which I have provided regarding this claim is correct. I understand that the penalty for knowingly and willfully making a false claim or a false statement in connection with a claim is a fine of up to $10,000 or imprisonment for up to 5 years or both. (18 USC 287, 1001)

2. I hereby waive my VA compensation. DA Form 3053 and VA Form 21-8951 are enclosed.

3. Privacy Act statement is enclosed.

DATE	SOLDIER'S SIGNATURE

CAL NG Form 37-2H (1 Apr 89)

APPENDIX F (continued)

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

NAME	DATE OF INJURY OR ILLNESS	TIME OF DAY
	/ /	☐ A.M. ☐ P.M.

HOME ADDRESS (Number, Street, City, Zip Code)

WHERE DID ACCIDENT OR EXPOSURE OCCUR (Number, Street, City, Zip Code)

DESCRIBE THE INJURY OR ILLNESS AND HOW IT OCCURRED

NOTICE OF POTENTIAL ELIGIBILITY FOR BENEFITS

You may be entitled to one or more of the following benefits provided for you at your employer's expense, depending upon your individual situation: medical treatment, compensation for lost time related to this injury, compensation for a permanent impairment, vocational rehabilitation, and/or death benefits. Compensation is based on a percentage of your earnings. If you are hospitalized or off work for more than 3 days as a result of this injury, you will receive your first payment of compensation or a notice within 14 days of your employer's notice or knowledge of this injury. Along with your first payment, you will also receive a pamphlet describing more fully compensation benefits and procedures.

YOU MUST FILE THIS CLAIM FORM WITH YOUR EMPLOYER TO PROTECT YOUR RIGHTS

Failure to file this claim form will preclude you from receiving any late payment penalty that may be due and will also preclude your right to pursue further legal remedies.

If you need assistance in completing this form or have any questions regarding your work injury you may contact the State of California Office of Benefit Assistance and Enforcement by calling 1/ (415) 557-1954. This service is provided to you at no cost. You also may consult an attorney.

I gave this form to my employer on (date) _____, 19_____.

EMPLOYEE: Keep copy marked "EMPLOYEE'S TEMPORARY RECEIPT" until you receive the dated copy from your employer.

EMPLOYER FILLS OUT THIS PART

Date of knowledge of injury	Date claim form was provided to employee	Date claim form was received
/ /	/ /	/ /

Name of Employer

Signature of Employer/Representative

Employer: You are required to date this form and provide copies as marked, to your insurer and to the employee, dependent or agent who filed the claim.
Signing this form does not necessarily constitute acceptance of a claim.
Please return original to your local State Fund office.

STATE COMPENSATION INSURANCE FUND

SCIF 3301 (NEW 1 90)

STATE FUND COPY

APPENDIX F (continued)

PLEASE TYPE ALL INFORMATION, IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain last copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** P.O. BOX 807 SAN FRANCISCO, CA 94101-0807 Telephone: (415) 565-1344	OSHA Case or File No.

PICA XXX ELITE XXXX ← TYPEWRITER ALIGNMENT GUIDE → PICA XXX ELITE XXXX

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. FIRM NAME — DIVISION — 1A. POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP) — 2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP) — 3A. LOCATION CODE
4A. NATURE OF BUSINESS e.g., painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
4B. TYPE OF EMPLOYER: PRIVATE STATE CITY COUNTY SCHOOL DISTRICT OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME — 7. DATE OF BIRTH (MM-DD-YY)
8. HOME ADDRESS (Number and Street, City, ZIP) — 8A. PHONE NUMBER
9. SEX: Male Female — 10. OCCUPATION (Regular job title, not specific activity at time of injury) — 11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED — 12A. DATE OF HIRE (MM-DD-YY)
13. HOURS USUALLY WORKED: HOURS PER DAY — 13A. DAYS PER WEEK — 13B. TOTAL WEEKLY HOURS — 13C. Under what class code of your policy were wages assigned?
14. GROSS WAGES/SALARY: PER: HOUR DAY WEEK TWO WEEKS MONTH OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City) — 15A. COUNTY — 15B. ON EMPLOYER'S PREMISES? YES NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin; in cases of strains, the thing he was lifting, pulling, etc.
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc. — 19B. PART OF BODY AFFECTED e.g., back, left wrist, right eye, etc.
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
22. DATE OF INJURY OR ILLNESS (MM-DD-YY) — 23. TIME OF DAY a.m. p.m. — 24. Did employee lose at least one full day's work after the injury? (MM-DD-YY) NO YES — Date Last Worked:
25. HAS EMPLOYEE RETURNED TO WORK? (MM-DD-YY) No, still off work Yes, date returned: — 26. DID EMPLOYEE DIE? (MM-DD-YY) NO YES — Date of Death:
27. WAS ANOTHER PERSON RESPONSIBLE? NO YES — 28. WAS INJURED AN EXECUTIVE OFFICER OR A PARTNER? NO YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 (REV. 8-88)

FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.

FORM 5020 (REV 5) April 1987

APPENDIX G
REFERENCES FOR LINE OF DUTY INVESTIGATIONS INCAPACITATION PAY AND MEDICAL BOARDS

AR 600-8-1	-	Army Casualty and Memorial Affairs and Line of Duty Investigations
AR 40-3	-	Medical, Dental and Veterinary Care
AR 40-501	-	Standards of Medical Fitness
AR 315-381	-	Reserve Components Incapacitation System
AR 635-40	-	Physical Evaluation for Retention, Retirement, or Separation
NGR 600-3	-	Line of Duty Determinations (superseded by AR 600-8-1)
NGR 40-501	-	Medical Examination for Members of the Army National Guard
NGR 40-3	-	Medical Care for Army National Guard members
NGB Pam 37-5	-	Management of Incapacitation Pay and Allowances
DODPM	-	Department of Defense Pay and Entitlements Manual

CAL ARNG Pam 40-2

9 July 1990

(CAMP-SB)

BY ORDER OF THE GOVERNOR:

OFFICIAL

ROBERT C. THRASHER
Major General
The Adjutant General

OFFICIAL

KURWOOD F. REYNOLDS
COL, INF, CAL ARNG
Administrative Officer

DISTRIBUTION:
A, M